Autism Spectrum Australia (Aspect) Response to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability Issues Paper on Restrictive Practices 26 May 2020

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Introduction

Autism Spectrum Australia (**Aspect**) is Australia's largest autism-specific service provider, with one of the biggest autism-specific schools programs in the world. We are a not-for-profit organisation and our mission is to work with people on the autism spectrum of all ages to deliver evidence-informed person-centred solutions. All of our work is focussed on understanding, engaging and celebrating the strengths, interests and aspirations of people on the autism spectrum.

Aspect supports and welcomes the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* and encourages others to read our previous submissions, which are available on our website.

Aspect is committed to the rights of people with disability. Australia is required under the UN Convention on the Rights of Persons with Disability to respect, protect and fulfil the human rights of people with disability. This includes supporting students and participants to understand and advocate for their rights.

As a national organisation, Aspect delivers services to people of different ages and abilities, in different settings (including schools, homes and communities) and in different states and territories in Australia, many of which have different definitions, requirements and processes for monitoring and reducing restrictive practices. For example, across Australia, what happens in schools for persons with a disability is different to disability services, unless you are in the Australian Capital Territory (ACT) where recently a new approach monitors practice across both settings under the responsibility of the ACT Senior Practitioner.

Aspect continually endeavours to improve our culture, understanding, expertise, resourcing, and training in restrictive practices, choosing to share research and practice that helps to achieve the reduction and elimination of restrictive practices. Aspect supports and commits to the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector.

We have answered the thirteen questions posed in the Issues Paper on Restrictive practices of 26 May 2020 (**Issues Paper**) in the following submission however we have used a different format to minimise repetition of information. For ease of reference, the response is divided into two sections, (1) Restrictive practices, impacts and reduction methodology; and (2) Aspect's current approach to restrictive practices use and reduction within Aspect schools and services.

In short, while Aspect does not support a zero tolerance approach it does believe in working towards reduction and elimination of unnecessary practices, and only using legal restrictive practices as a matter of last resort to ensure the safety of the individual themselves and the people around them. To this end, Aspect has established various leadership positions and committees across all Aspect disability support services and schools to lead safeguarding and positive behaviour support practices, and to ensure that staff are committed to the reduction and elimination of restrictive practices where possible.

Section 1: Restrictive Practices, impacts and reduction methodology

What are restrictive practices?

It is essential to define restrictive practices carefully in order to better understand the full range of practices, and the complex situations and strict conditions under which they are used.

In line with the Issues Paper, Aspect also broadly understand that restrictive practice means any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability (NDIS Quality & Safeguards Commission Framework, 2016). Nationally, restrictive practices fall under several agreed categories, being seclusion, chemical restraint, mechanical restraint, physical restraint and environmental restraint. Some jurisdictions expand on this list of categories, such as the ACT, which is currently the only state to monitor what is known as "psychosocial restraint practices", under the restrictive practice category of “verbal directions, or gestural conduct, of a coercive nature” as defined in the Senior Practitioner Act (ACT) 2018. Victoria also acknowledges psycho-social restraint under the category of “other restrictive interventions”, however these practices are not subject to any monitoring or reporting (Office of the Senior Practitioner Guide, 2010).

Aspect considers that broad statements such as restrictive practices are *‘a disability specific form of violence’* (as per the Issues Paper, page 2) do not reflect the range, complexity and conditions under which restrictive practices are used or the duty of care that service providers have (including Aspect) to keep people safe. Within each defined restrictive practice, there are huge variations in how that restrictive practice might be used. This includes differences in the action, intensity, duration, intrusiveness and impact of the restrictive practice on the person, as well as potential impacts on other people around them at the time of the restrictive practice use. Aspect acknowledges the concern highlighted in the Issues Paper that restrictive practices are in conflict with people with disability’s human rights and could be used in an abusive context. However, Aspect is of the view that restrictive practices used as a last resort, for the least amount of time possible, and in the least restrictive way is a justified safety mechanism provided that any use of restrictive practices is always appropriately monitored, legal and considered in context of the individual’s needs.

Importantly, the use of restrictive practices as a last resort safety mechanism must not sit alone but instead must be part of a broader approach to positive behaviour support, with a focus on quality of life, skill development and consideration of environmental changes which identify causes and preventative measures for any challenging behaviour, or situation that may lead to the need of a restrictive practice use to protect the rights or safety of the person or others.

This balance between duty of care to the individual and others involved in their care and upholding human rights is complex. While most situations can be managed through risk management processes, challenging behaviour can sometimes be unpredictable and can at times pose a safety concern for the individual or others around them. In such circumstances, the use of authorised restrictive practices may be appropriate.

Aspect considers ‘challenging behaviour’ to be persistent behaviour that puts the safety of people at risk or that limits a person’s ability to have a good life. The challenging behaviour is considered an interaction between the individual (including their current and past experiences and learnings), other people in their lives and the environments, communities and cultures in which they live (Hastings, et al, 2013). Behaviour is called ‘challenging’ because it challenges everyone who supports the person to understand why it is happening and to work together to find a solution. Challenging behaviour does not include regulating behaviours that are typically part of the autism spectrum such as ‘stimming’.

Aspect considers an 'authorised restrictive practice' to be a restrictive practice which is used as a last resort, permitted by the relevant law, implemented in accordance with a behavioural support plan and in accordance with the duty of care owed to the individual and others, monitored and evaluated, removed as soon as it is no longer necessary and used always with a view to being faded over time. Any references to an authorised restrictive practice in this paper should be read in this context.

1. Conditions for restrictive practice use

State and national regulatory bodies place certain conditions on the use of, monitoring and authorisation requirements for the use of restrictive practices. Currently there is no national consistency on how these processes are applied within disability services. This is because States maintain the authorisation and consent processes and the NDIS Quality and Safeguards Commission sets the conditions for the use of restrictive practices through the NDIS (Restrictive Practices and Behaviour Support) Rules 2018 and requires reporting of use and the registration of behaviour support plans containing restrictive practices. Furthermore, there is no framework for restrictive practice use that links the use of restrictive practices in disability services to other types of service provision where people with disability may be subject to those same restrictive practices e.g. education services, aged care facilities, health care institutions. Restrictive practices should be applied and treated consistently, regardless of where the person is located and regardless of what type of service the person receives.

The NDIS (Restrictive Practices and Behaviour Support) Rule 2018 reporting requirements allow for any restrictive practice use to be most importantly and appropriately reviewed to ensure the practice was warranted and that it was used as a last resort, for the least possible amount of time and in the least restrictive way. Restrictive practices use outside of NDIS services however are not subject to this review.

2. Defining restrictive practices

Aspect acknowledges the definitions of restrictive practices in the Issues Paper, and seeks to show the breadth and complexity of practices that can fall under a single category. To that end, Aspect has provided below additional recommended explanations for each of the restrictive practices categories to clarify the use of the practice.

a) Seclusion

Seclusion is specifically the sole confinement of a person, as opposed to the person being instructed to remain in a space with other people (see environmental restraint). This could be behind a partition or gate, in another room, and can include where a person is physically

able to leave but their voluntary exit is implicitly or explicitly denied. Measures must be implemented to ensure the safety and wellbeing of the individual, for example line of sight may be maintained, or frequent visual checks could occur. Seclusion should be implemented only for a set period of time and the supervision, safety and accessibility of food, drink and bathroom facilities must always be considered when secluding a person.

An example of a use of seclusion within industry guidelines (e.g. FACS NSW Seclusion guidance) that may be an authorised restrictive practice contained within a behaviour support plan is the temporary withdrawal of staff and others in a room or space, leaving an individual alone for a limited period when they are engaging in physically harmful behaviours towards others, to meet the duty of care for staff and other individuals. This should only be used to prevent a person with disability causing physical harm to others in accordance with the individual's behaviour support plan, and never as a punitive response. In meeting its duty of care to staff and other individuals, organisations must not neglect their duty of care to the person with a disability. As mentioned in the paragraph above, any use of a seclusion restraint must be implemented safely, appropriately and to avoid unnecessary distress.

Seclusion does not include an individual voluntarily choosing to spend time alone in a space where they are free, and have the skills to leave at any time e.g. a person with disability living in independent supported living choosing to spend time alone in their bedroom.

In NSW, seclusion of a school aged person under 18 years is prohibited within disability services.

b) Physical restraint

Physical restraint is 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 includes:

- Preventing, or controlling the movement of a person from one place to another using a physical hold; and
- the use of physical force in order to administer medical treatment (such as, holding a person to take their blood or to give them medication/injections against their will – acknowledging that circumstances in which medical treatment can be administered without consent of the individual is severely restricted by law, and varies significantly between disability and mental health services).

Examples of a use of physical restraint within industry guidelines (e.g. NSW FACS physical restraint guidance) that may be an authorised restrictive practice contained within a behaviour support plan are:

- the temporary holding of a person's hands to allow others time to leave the environment safely so the person can have a quiet space to calm;
- holding someone's hand or otherwise restricting their movement near busy roads if they have limited road safety awareness; or
- two staff physically holding a person until they can be safe towards others, or to move someone to a safe place.

To meet best practice, any physical holds used must be evidence based techniques that minimise any risk of harm to the individual, and should not cause any pain or discomfort. Any

staff using physical holds must be trained and assessed in their use by an accredited trainer (an example of such a training program is the Management of Potential or Actual Aggression (MAPA©)). Aspect recommends that such a training requirement should be reflected in any national framework to maximise duty of care and minimise risk of harm.

Physical restraint does not include physical assistance or support:

- to enable activities of daily living such as physically assisting a person to dress, shave, or brush their teeth, where the physical contact is non-coercive;
- to help people to learn new skills, such as physically guiding a person's hand to use a tool such as a knife for preparing food or a pencil to write;
- for therapeutic purposes such as a physical or occupational therapist providing physical support or resistance to assist a person to stretch or exercise a muscle;
- that is age appropriate e.g. holding a young child's hand to cross the road in line with community guidance of road crossing expectations (see Children Crossing the Road guidance from the Pedestrian Council of Australia);
- for age appropriate hygiene support practices e.g. gentle holding of an infant on a change table while nappy changing to prevent them from falling, or preventing their hands from inadvertently accessing the nappy contents; or
- to comply with 'duty of care' expectations – 'duty of care' is defined broadly as taking action, where reasonably required, to prevent or reduce foreseeable imminent harm from occurring to a person e.g. pulling someone out of the path of an oncoming car while they were running towards the road and this may be the only realistic option to ensure duty of care is observed in those circumstances.

c) Chemical restraint

Chemical restraint is the use of medication or chemical substances for the primary purpose of influencing a person's behaviour. This might include the use of psychotropic PRN (as needed) medication to temporarily subdue behaviours that are putting the person or others at risk. Chemical restraint can also be used on a daily basis or routinely to pre-emptively manage a person's behaviour and/or hormones and reproductive systems. Depending on state/territory legislation this category can include medications used to manage a person's behaviour when undergoing medical treatment and procedures, or menstrual management for the purpose of effecting behaviour practices. Chemical restraint can also include the administration of medication without the consent of the individual (e.g. hiding medication in food without the individual's awareness that the medication is in there).

An example of a use of chemical restraint within industry guidelines (e.g. NSW FACS chemical restraint guidance) that may be an authorised restrictive practice contained within a behaviour support plan is the administration of a PRN medication to assist an individual to calm when displaying self-harming behaviours, when all other strategies within the person's behaviour support plan have not been effective in preventing the self-harm from occurring.

Chemical restraint does not include any medication prescribed for a diagnosed mental or physical illness e.g. treatment for depression with anti-depressants or providing pain relief for a headache. There is some ambiguity for disability service providers about the prescription of routine medications for mental health conditions that are not scheduled as the primary use for that medication (also known as "off label" prescribing), and whether this may constitute a regulated chemical restraint. For example, a person with disability may be prescribed a

routine anti-psychotic medication to assist with their anxiety by their psychiatrist, however this anti-psychotic is not scheduled for anxiety. The disability service provider is informed of this new medication for administration and must seek advice on whether a behaviour support plan containing the new medication is required as a chemical restraint, or whether this will not be required due to the intention of the medication to treat the person's anxiety as opposed to modifying their behaviour. This ambiguity for disability service providers is likely to occur when the provider does not manage the individual's primary health care appointments or has not been involved in the arrangement of the medication. In these circumstances the medication is prescribed by medical practitioners and usually arranged by the person themselves, or responsible person/family of the person with disability, and only included in behaviour support plans or administered by staff under direction of the medical practitioner. Some states (ACT, QLD) have developed a form for the prescribing doctor to complete regarding the purpose of the medication to assist with this, however there is no national guidance on what challenging behaviours, or the impact of the challenging behaviours on the individual's life, may be a justification for seeking a medication for the purpose of addressing challenging behaviours. Aspect suggests that further clarity is required to understand the complexity of chemical restraint administration.

d) Mechanical restraint

Mechanical restraint is the use of a device to prevent, restrict or subdue a person's movement for the primary purpose of influencing a person's behaviour. Mechanical restraints might include:

- restrictive clothing such as an all-in-one body suit used to prevent a person with a bowel condition from using their fingers to reduce discomfort;
- the practice of engaging brakes on wheelchairs or disabling mobility devices where the individual is not able to disengage the breaks or enable the device to restart;
- a splint used to straighten a person's arm specifically to prevent self-injury; or
- a seat belt buckle guard or harness to prevent someone from leaving their seat in a vehicle (Note: In some jurisdictions and circumstances, a seat belt buckle guard is not considered a restrictive practice).

An example of a use of mechanical restraint within industry guidelines (e.g. NSW FACS mechanical restraint guidance) that may be an authorised restrictive practice contained within a behaviour support plan is the use of a helmet fitted to an individual who engages in frequent and long lasting episodes of head-banging to reduce the potential for injury while replacement behaviours are taught.

A mechanical restraint does not include restraining individuals in accordance with national child restraint laws (see National Child Restraint Laws section on the Transport for NSW website) or aids used for prescribed therapeutic use e.g. splints for assisting with walking, or a lap sash use in a wheelchair to prevent falls.

Aspect is concerned with the examples of mechanical restraint provided by the Issues Paper such as "tying a person to a chair in a classroom" and "taking a person's communication device away from them". Aspect considers these examples not to be an authorised use of a restrictive practice or contained within a behaviour support plan. Specifically, Aspect considers those to be examples of a prohibited practice, which is abuse.

e) Environmental restraint

Environmental restraints restrict a person's free access to all parts of their environment, including items or activities (as relevant to age appropriateness). Environmental restraints include:

- locked access to items in cupboards or fridges, or creating barriers to access items that would usually be accessible;
- locked rooms or gates;
- verbal or gestural instruction that a person does not have free access to leave or enter an area, or participate in an activity that they would normally have access to until they are safe (this historically may have been known as exclusionary time-out, and does not involve sole confinement, which is seclusion);
- limiting service such as shorter hours or being sent home early e.g. sending a person home from a service or a student home from school as well as suspension and shorter hours of service due to behavioural challenges; and
- limiting access to a person's own items e.g. holding a person's wallet and money until they arrive at a pre-determined location for making purchases to ensure they have the correct money to access their preferred daily activities

Example of a use of environmental restraint within industry guidelines (e.g. NSW FACS environmental restraint guidance) that may be an authorised restrictive practice contained within a behaviour support plan is preventing a school student from absconding from school grounds without their parent/carer or guardian or staff supervision; or a fridge lock that prevents a person with a choking risk from accessing food unsupervised.

Environmental restraint does not include age appropriate practices to fulfil a duty of care such as locking cleaning supplies and chemicals or keeping sharp knives out of reach around young children.

f) Psychosocial restraint

Psychosocial restraints can include the use of inter-personal interactions, generally with some form of power and control dynamic or psychological pressure aimed at controlling or influencing a person's behaviour. Psychosocial restraints include:

- 'Over-correction' responses where:
    - the person is required to repeat a task or action with the requested behaviours in an exaggerated manner (e.g. a person throws some food and in response is asked to clean up not only the mess they made but the entire room);
    - desired social interaction is withdrawn for periods of time as a consequence without a reasonable rationale; or
    - privileges or participation of activities are withheld as a consequence for non-compliance or disagreements (Webber et al, 2010).
- 'Response cost' (also known as 'consequence driven strategies') programs or regimes involve the withholding of, or loss of, predetermined items or activities of positive value, or taking away access to a positive experience and is enforced as a consequence of challenging behaviour e.g.:
    - removing access to a personal gaming device or taking away reward tokens previously earnt;

- depriving a person of age from making appropriate lifestyle choices by dictating their schedule (e.g. bedtime); or
- constantly telling the person not to do something, or that doing what they want to do is not allowed or is too dangerous without justification.

There are concerns about the use of psychosocial restraints and how it, at best, prevents people to live self-determined lives, and, at worst, may have people live their lives traumatised and in fear (McVilly, 2019), and how the use of them inhibits the upholding of human rights, choice and control. Psychosocial practices tend to be punitive in nature, can be seen as aversive, eliciting fear or intimidating. It is akin to the ordinary meaning given to terms such as 'harassment' and 'bullying' with little opportunity or capacity for the individual to protest or escape due to the power imbalance. It is therefore also highly susceptible to misuse and abuse, and is unrecognised and used without regulation, monitoring or review in most Australian jurisdictions, whilst prohibited in others.

Psychosocial restraint is a practice that may also be used in the general population such as in schools and education settings where discipline policies are not subject to restrictive practice monitoring for its use. As psychosocial restraint does not meet good Positive Behaviour Support (PBS) practice, it is considered a prohibited practice in all Aspect schools and services.

> *"We know little about the long-term impact of psycho-social restraint on people with a cognitive impairment, but it is likely that psycho-social restraint may add to the trauma already experienced by the person especially if the person doesn't have the cognitive ability to understand the reason for restraint." (Webber et al., 2010)*

Psychosocial restraint is not the use of therapeutic techniques known as 'sabotage' (Coogle et al., 2013) which can be used as part of a comprehensive communication program. Sabotage is an approach where motivating items, such as a favourite toy, are put just out of reach of a young person learning to communicate to encourage the use of an available communication device or strategy. Communication is supported to promote success and the practice faded quickly as communication becomes effective. Access to food water or other essential items is always provided and the practice is never used punitively, with all communication attempts rewarded.

3. Prohibited practices

The context of the use of the term 'restrictive practices' is that of authorised use to protect the safety of a person or others in the strict and limited last resort circumstances discussed above. It is important to differentiate restrictive practices from prohibited practices.

The use of prohibited practices is a misuse of restrictive practices, whether intentional or unintentional, and constitutes abuse which is a clear unjustified violation of human rights. While prohibited practices are not the only form of abuse, it is a type of abuse which adds to the long history of violence, abuse, neglect and exploitation experienced by people with a disability. Violence, abuse, neglect and exploitation are criminal, unethical and are strictly prohibited.

Examples of potential misuse of restrictive practices that would be prohibited may include:

- using a restrictive practice alone as a 'quick fix' (e.g. restricting an adult's access to sharp items without supporting skill development to learn safe use of those items and remove the need for the restriction);
- using a restrictive practice as a substitute for positive behaviour support (PBS) strategies;
- overusing a practice (such as seclusion for long periods) or using it outside of the specified guidelines;
- using the restrictive practice as a permanent part of a person's support, even when they may not be needed;
- using a restrictive practice punitively;
- using a restrictive practice to subject a person to cruel or inhumane treatment; or
- continued use of an unauthorised restrictive practice.

Such prohibited uses of restrictive practice do not allow for the assessment, planning, environmental changes and skill building that may be required to address the underlying communication or cause of challenging behaviour.

These challenging behaviours may be functional and adaptive to circumstances such as:

- reactions to circumstances in which a person feels forced to do something they do not want to do;
- an attempt to communicate a person's own needs and wants through barriers of communication impairments;
- emotional reactions to the environment or how the person feels they are being treated;
- responses to pain or mental health conditions;
- responses to past trauma or abuse;
- lack of skill building or appropriate role modelling in all or most of the person's lived environments;
- the impact of certain syndromes which lead the person to self–injure; or
- being unable to understand or make sense of the person's environment or the interactions with others (Emerson & Einfeld, 2011).

Aspect has consulted the Aspect Practice Think Tank, a group of paid consultants on the autism spectrum, when drafting this submission. The Think Tank specifically noted that therapies that impel people to complete actions that are aversive such as making eye contact and that take away helpful coping strategies such as stimming or other approaches that do not respect human diversity, should also be expressly prohibited. Aspect strongly supports this recommendation.

Some jurisdictions have prohibited specific types of restrictive practice, or types of use of the practice to reflect the potential negative impact and safety considerations. For example:

- In NSW the Restrictive Practice Authorisation Policy (2019) prohibits:
    - aversive practices;
    - overcorrection;
    - the misuse of medication;
    - denial of key needs;
    - seclusion of children and young people under the age of 18;
    - unauthorised use of restrictive practices; and
    - any act in any way which:

- degrades or demeans a person,
- may reasonably be perceived by the person as harassment or vilification, or
- is unethical.

- In NSW the Children and Young Persons (Care and Protection) Regulation 2012 further prohibits for person's aged 18 years and under:
  - any form of corporal punishment;
  - any punishment that takes the form of immobilisation, force-feeding or depriving of food; and
  - any punishment that is intended to humiliate or frighten the person.
- In Victoria the Restrictive Practice prohibitions under section27(5B) of the Disability Act 2006 (Vic) prohibits:
  - certain types of physical restraint positioning including supine, prone, pin downs, takedown techniques, basket holds, restraints that effect the respiratory or digestive functioning of the individual, or restraints that push the head forward onto the person's chest, cause pain, hyperextension of joints or apply pressure to the joints or chest of the individual; and
  - restrictive practices used by a registered National Disability Insurance Scheme (**NDIS**) provider on any person with a psychosocial disability unless they also meet the requirements for another type of disability under section 24 of the NDIS Act 2013 (Cth).

What do we know about restrictive practice usage?

1. Frequency & prevalence of restrictive practice

Restrictive practices are used in complex circumstances. People's situations (their health, mental health, histories, disabilities, carers, supports, interactions and environments) can result in behaviours that challenge those around them (also known as challenging behaviours) and place the individual at risk. Sometimes these circumstances require the temporary use of a restrictive practice.

It can be difficult to assess exactly how often most people with disabilities are subjected to restrictive practices as people with disabilities engage and move across a range of settings and sectors where they may be subjected to different restrictive practices. However, from Aspect's industry and organisational experience working with people with disabilities, other providers, and as evidenced in research, it is likely that people with disability are very often subjected to restrictive practices, for example, routine restrictive practices such as environmental, chemical or mechanical restraint can be used on a daily basis and in different environments, such as at home, in school or out in the community.

The British Medical Journal published a paper by Sheenan *et al* (2015) that reviewed the medical records of over 33,000 adults with a disability. About a third of those in the study, or 11,915 people, had a record of challenging behaviour, 47% of whom – or 5,562 people – had received antipsychotic drugs. Only 13%, or 1,561, had a record of severe mental illness. The paper concluded

> *"The proportion of people with intellectual disability who have been treated with psychotropic drugs far exceeds the proportion with recorded mental illness. Antipsychotics are often prescribed to people without recorded severe mental illness*

but who have a record of challenging behaviour. The findings suggest that changes are needed in the prescribing of psychotropics for people with intellectual disability. More evidence is needed of the efficacy and safety of psychotropic drugs in this group, particularly when they are used for challenging behaviour."

Concerns about the over use of medication in lieu of good practice support have been expressed for many years (Tsiouris, 2009) and psychotropic medications are strongly associated with adverse events including psychological and physiological side effects such as sedation and weight gain, that impact a person's quality of life (Scheifes, 2015) as well as shortening life expectancy.

Through Aspect's work with the broader community, families, schools and other sectors in Aspect Therapy and PBS workshops and consultancies, it has been anecdotally observed that other restrictive practices such as seclusion or physical restraint are used less frequently in most disability specific settings, but may be more regularly used with people with disabilities in hospital or detention settings. Some disability services are more likely to utilise restrictive practices than others, for example, it is more likely to see routine restrictive practices in place in a group home environment compared to supported independent living.

It is also important to look at how some people with disability will be impacted by restrictive practices that could be in place for another person with disability. For example, a fridge lock in a group home may impact other residents of that group home if support is not provided to other residents to independently unlock the fridge. It is important in such circumstances to provide access (e.g. when the person with the restriction is not around) or allow others to have access safely and independently (via a key or messaging to staff).

2. Factors that influence restrictive practice use

Aspect does not collect data on restrictive practice use with people of different ages, sex, gender identity, sexual orientation or race. Anecdotally, authorised restrictive practices should not be used differently based on those demographics, as ongoing authorised restrictive practice is based on the needs of the situation as well as the individual, and in accordance with stringent restrictive practice requirements and oversight. There is more scope however for bias to occur in unauthorised use of restrictive practices where the decisions for restrictive practice use are likely occurring without appropriate oversight (including external and independent oversight), thus allowing for more opportunity for bias and/or discrimination to have an impact. Different environmental settings and relevant demands of the situation in closed places with little visibility to external reviews of practices may also be a factor in the formation of a bias in restrictive practice use. The use of societal/cultural expectations to condemn unauthorised use while not necessarily inappropriate, does not consider the real reasons why unauthorised use occurs and therefore may not truly address the root of the issue to prevent future unauthorised use.

In Aspect's experience and observations of different contexts where Aspect has provided positive behaviour supports, it is apparent that restrictive practices are used disproportionally in situations that are more complex. This includes more types of restrictive practice, used more frequently and for longer amounts of time. These situations are characterised by high levels of challenging behaviour, ad hoc implementation of strategies and poor coordination of support, high levels of stress and distress of all involved (including the person), support that is not matched to the need of the person and their carers and can be due to high turnover of staff, where support needs and adequate training are harder to maintain without consistency of support workers.

a) Restrictive practice use with age

It is important to consider how people with disability are subjected to restrictive practices across the lifespan. Children, for example, could be subjected to more regular and developmentally normalised restrictive practices like restraints in vehicles (e.g. seat-belt buckle guards or harnesses used to prevent someone from undoing their seatbelt and leaving their seat whilst the vehicle is in motion) or locked cupboards and fridges to prevent access to harmful objects or foods. Restrictive practices in these circumstances are typically used proactive safeguards, as the risk of using the restrictive practice is less than the risk in the potential resulting accident that may occur without the safeguard in place. Adolescents with disability may be subjected to different types of restrictive practices as they move across educational settings, as well as exposure to more experiences outside of the home. In Aspect's experience and industry observations, adults with disability may be subject to restraints and restrictive practices that have been in place for many years, and have not been assessed or faded from use for long periods of time. In addition, elderly guardians and parents may not be aware of relevant industry state or national restrictive practice guidelines and recent changes in state/territory and national frameworks for authorising and monitoring restrictive practices. Adults living within group homes may have less external oversight of their subjection to restrictive practices making this more difficult to assess.

Restrictive practices can also start as not restrictive as they are considered age appropriate, but then become a restrictive practice when they are no longer considered age appropriate by community standards. The practice might still be necessary in the short term to allow relevant skill development (e.g. restricting access to spending money is an appropriate measure parents would take with their children and adolescents as they learn money handling and appropriate decision making skills about purchases). However adults are typically free to spend their money however they choose. It is important to note that in these circumstances, what makes the practice a restrictive practice is the presumption that by that age, the individual should have developed the skills necessary not to need the restriction. Not everyone develops these skills at the same age or indeed the same stage of life. It is important that necessary supports and safeguards are allowed to remain in place while concurrently emphasising assessment of the person's needs, skill building and less restrictive options to ultimately fade the practice as soon as it is no longer necessary.

b) Restrictive practices in education settings

In Australia, with the exception of the ACT, there is no regulatory oversight of restrictive practice use in education settings. Historically, education institutions had a culture and approach favouring 'discipline', rather than 'positive behaviour support' in schools, where teaching was tailored to the group and not the individual. While education settings have evolved with research and practice to become more inclusive, individualised and supportive settings, it is possible that they may remain largely institutional in many aspects such as behaviour support, where oversight on the use of these practices, both positive and negative, are often unmonitored.

Behaviour management and support policies are developed by the relevant state education body for public schools, to be implemented in practice by each individual school. Non-government schools such as independent schools and religious schools will develop their own policies for implementation. NSW Education Standards Authority (NESA) and South Australia Education Standards Board (ESB), require registered non-government schools to have policies relating to discipline, suspension and expulsion of students attending the school that are based on principles of procedural fairness and prohibit corporal punishment. Anecdotally, Aspect has observed through our workshops and consultancies that

psychosocial restraints under the guise of 'discipline' are largely used within education settings, with frequent use of consequence driven strategies that result in regular exclusion for students with disability in various school-based activities and opportunities.

A Deloitte Access Economics review of Education for students with disability in Queensland state schools (2017), stated "The survey and school consultations revealed that restrictive practices are used in a range of contexts and for a range of reasons both related and unrelated to physical safety. The parent survey revealed that approximately one in four parents and carers believed that their child had been subjected to restraint at school. " (p.108). Similar reviews and surveys in other jurisdictions on behaviour management in education have suggested that restrictive practices are highly prevalent in education settings without clear parameters for use, monitoring, data recording or regulated oversight, with all of the student population (NSW Ombudsman, 2017), although disproportionally amongst those students with disability.

Currently, Australia has no regulatory protective framework to protect children with disability from being subjected to behaviour modification and restrictive practices in schools. Some jurisdictions such as Queensland and ACT education departments are working towards improvements in behaviour support planning where a restrictive practice may be included as a last resort safeguard, monitoring practices and a reduction of the necessity for restrictive practice use. The NSW Department of Education has reviewed its own related policies and made suggestions that greater clarity, prevention and scrutiny is required in relation to restrictive practice use (NSW Ombudsman, 2017).

c) *Restrictive practices in the home and community*

Restrictive practices out in the community or in individual homes that are not put in place as part of an NDIS or state disability service behaviour support plan are unregulated and often unknown. Australia does not have clear guidance for parents and the community on what is appropriate behaviour support or discipline that respects human rights. Neither the rights of children and individuals with disability are often not widely promoted for community standards in business operations nor with families who are child rearing. This is evidenced by there being a lack of clearly applied laws that prohibit the use of restrictive or prohibited practices as behaviour management responses at home (CFCA, 2017), and that the level that triggers abuse and neglect concerns varies from state to state.

Physical punishment from a parent to a child for the purposes of discipline, for example, while not encouraged, is allowed to continue with some limitation of use (CFCA, 2017) because the State and communities grant families a measure of discretion in how they discipline their children. Such practices permissible by community standards for childhood discipline are often continued towards people with disability regardless of their age. This infantilises people with disability that may be reliant on others for support due to the power imbalance in the relationship.

Family and community education on human rights and appropriate management of challenging behaviours is often a key piece of positive behaviour support implementation. Aspect provides workshops, individual training and support to address these areas for participants, families, professionals and the broader public. While no specific data has been collected from these, anecdotally, many participants at our workshops, training and individual consultancies had been simply unaware of what constitutes restrictive practices, or the reason why they might be restrictive.

d) Restrictive practices in disability specific settings e.g. day programs residential programs

Chan et.al. (2013) explored the use of restrictive practices in Australian disability respite environments. The research team utilised existing data on restrictive practice frequency obtained as part of Victoria's regulated mandatory reporting of restrictive practice use. They found that 28% of restrictive practice use was reported from respite care services. These participants were generally male, in the younger age brackets (average age 21 years old) and had a diagnosis of autism.

Some studies have also noted that in residential settings, disabilities associated with communication difficulties such as autistic individuals with limited speech or alternative communication techniques, as well as those who have a hearing or speech impairment were more likely to be associated with greater instances of restraint use (Webber et al., 2014; Webber et al, 2019) and for longer periods of use than people with disability that did not have a communication difficulty or autism diagnosis (Richardson et al., 2019).

Historic research into disability institutional settings have evidenced widespread use of restrictive, prohibited and abusive practices. These conditions have been outlined in countless reports and have been the source of inquiries such as the Senate Committee on Community Affairs Inquiry on 'Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability'.

3. What are the effects of restrictive practices?

The risks of the *misuse* of restrictive practices are significant. These include physical injury, trauma, escalation of challenges, rapport breakdown and negative beliefs about the person, increased misuse of restrictive practices and minimisation of positive preventative strategies.

The effects of using authorised restrictive practices as safety strategies can also be varied and impact people differently. This can depend on the type of practice, how it is used, how long it is used and the history and understanding of the person. Negative effects of restrictive practices can include:

- immediate stress and distress for the person;
- potential escalation of challenges;
- longer term impact on the person's confidence, trust and self esteem;
- risk of re-traumatising a person;
- breakdown in relationship between the person with disability and those implementing the practice;
- lack of opportunity for skill development and reduction in quality of life; and
- effects and side effects of using chemical restraints.

The negative effects of using restrictive practices are likely to be worse if they are:

- without a plan or consideration of fading;
- used without positive or proactive strategies;
- used punitively;
- used inconsistently;
- used without consent by the person with disability and/or their person responsible; or

- perceived negatively by the person with disability, in particular regarding the motivation of the people implementing the practice.

McDonald *et al* (2011) used semi-structured interviews to understand the restraint experiences of eight 'service users'. People experience physical interventions as painful, emotionally distressing, and in some situations, where they did not understand why the restraint is happening (or think is it done punitively), as indistinguishable from abuse.

Research to date has suggested autistic individuals have an increased risk of developing post-traumatic stress disorder (PTSD) (Kildahl *et al*, 2020). There is also a higher rate of traumatic responses to these life events that are not considered 'traditional trauma' according to the Diagnostic and Statistical Manual of Mental Disorders (DSM–5) "Criterion A" for PTSD (e.g. bullying, bereavement) (American Psychiatric Association, 2013). It is probable therefore that restrictive practice use can contribute to or be experienced as a complex trauma in autistic individuals, which often is undiagnosed.

Industry best practice indicates that the effects of using restrictive practices are likely to be improved or managed if they are:

- planned and demonstrated to be clinically necessary;
- used alongside a behaviour support plan;
- used alongside positive and proactive strategies;
- used consistently by the people in the person with disability's life;
- used with the consent of the person with disability and/or their person responsible; and
- used by people supporting the individual or implementing providers with appropriate and professional motivation and this is communicated clearly to the person with disability.

Some positive effects of implementing restrictive practices can include:

- increased community access and participation (for example, harnesses in transport to allow safe travel);
- safety for the person with disability and others; and
- effective management of crisis and dangerous behaviours of concern to allow for skill development.

How can the use of restrictive practices be prevented, avoided or minimised?

There are two broad approaches to prevent, avoid or minimise restrictive practices.

(1) approaches that focus on positive preventative good practice disability support; and

(2) approaches that focus specifically on restrictive practice reduction.

1. Good practice disability support

a) Culture

Culture guides how staff are expected to behave and defines the set of shared beliefs and values of those within the organisation. An organisational culture is established from the commitment and expectations of its Board and the vision, mission and values of the

organisation. That commitment in turn underpins the strategy and direction of the organisation and the basis for which policies, procedures and systems are developed. Policies, procedures, and systems, reinforced by ongoing governance by the Board and senior leadership, tell management and staff what practices and behaviour will be tolerated and guide their decision making.. For good practice disability support, the commitment must respect and understand disability and diversity and explicitly promote all environments as welcoming and accommodating. Such a culture influences restrictive practice use by promoting a person's autonomy, understanding, respect for differences in behaviour, and encouraging people's communication (such as saying 'no'). This culture includes a trauma informed approach. Trauma-informed approaches help staff understand and be aware of trauma, to offer support that builds protective factors and avoids actions that might re-traumatize a person.

b) *Policy, procedure & staffing*

A deep understanding and good practice support for PBS is likely to occur where there is clear organisational policy, procedures and training relating to PBS as a person centred framework in situations where there is, or there is likely to be, a risk of challenging behaviour.

PBS has several important underlying principles and areas of focus, including the:

- use of positive and supportive methods to expand a person's behavioural repertoire – teaching and reinforcing more adaptive/positive behavioural responses to meet communication needs; and
- utilising systems change methods to redesign a person's environment to both enhance quality of life for the person and key stakeholders as well as to reduce challenging behaviours. The primary goal of PBS is to improve the quality of life for the person and all significant stakeholders (e.g. family members, support staff, educators, significant others) (Carr et al., 2002).

PBS is based on the premise that 'all challenging behaviour communicates important information', and PBS responds to challenges by assessing the function of that challenging behaviour and teaching effective functional replacement behaviours, as opposed to just trying to stop the challenge.

PBS is a complex intervention. PBS has multiple interacting elements and multiple agents that are required for its implementation. Research (e.g. Hassiotis *et al* (2018)) demonstrates that if PBS, as with all complex interventions, is not delivered to develop strong PBS plans and not implemented well, it is not helpful.

Aspect has witnessed the many positive benefits of a good PBS. We strongly support the use of PBS and believes that PBS staff training approaches could and should be implemented consistently across the disability sector and other sectors where people with disability are under the care of institutions (e.g. aged care, education and health sectors) to ensure that restrictive practices are only used in the context of good practice disability support.

PBS can also be a helpful approach to staff support (Gore & Baker, 2019), particularly where staff are working in situations where there is challenging behaviour, which can result in staff stress and burnout. There are a range of complex factors that influence staff stress and

burnout and the nature and type of incident will affect the emotional response of staff, with more negative responses reported to incidents that may also involve restraints. The PBS staff wellbeing framework uses a three-tiered approach to support, including:

- preventative supports for all ('universal level' or tier 1)
    - an organisational culture that prioritises staff wellbeing;
    - role clarity;
    - frequent competency-based training;
    - coaching;
    - supervision;
    - risk management;
- targeted secondary prevention (tier 2)
    - end of shift reviews;
    - informal and formal peer support; and
- intensive supports (tier 3) – post incident debriefing and support.

One key point at which staff experience significant risk to their emotional wellbeing is during and immediately following an incidence of challenging behaviour. Unfortunately, the research is not clear on the support that should be provided.

> *'There is clearly a need for greater clarity in relation to best practice in the manner in which staff are generally supported and specifically following incidents of behavioural disturbance, both in relation to the requirements for organisational learning and the post-incident emotional support of those involved'. (Baker, 2017)*

Baker lists the following guidelines:

- Strategies designed to provide emotional support for staff should be separated from the responsibility to provide organisational learning from the incident.
- A range of interventions should be offered on a voluntary basis.
- Adequate debriefing needs to be of sufficient duration and not too soon after the event, and carried out by trained experienced staff.
- Training of staff who debrief needs to fit the context.
- Debriefing should be carried out by clinicians who are familiar with the context of the work.
- Prior history of trauma may either sensitise or immunise staff to subsequent trauma, depending or not whether they had worked through earlier trauma. Getting staff to reflect on their own personal trauma history as a specific psychoeducational strategy, may well be helpful in facilitating each individual.

If there remains a foreseeable risk that has not been addressed or if staff report they feel that they do not know what to do or are not confident in similar situations, there is increased risk of staff burnout. This represents a risk then not only to the staff, but to the people with disability that they support. It is important that all staff are given the follow up coaching to build their confidence in managing crises into the future.

Australian PBS context

Unfortunately, the disability sector is significantly under-resourced with respect to experienced behaviour support practitioners, meaning that people with disability either wait lengthy times or are unable to access good PBS.

In Aspect's experience, the NDIS funding allocated to PBS plans often does not reflect the amount of work required to provide a good quality PBS service, resulting in PBS being less

than required. As each person with disability and their support networks needs are different, timeframes implemented by the NDIS Quality & Safeguards Commission for the lodging of PBS plans are often unrealistic. Aspect has observed that the pressures on behaviour support practitioners to meet timeframes and expectations often make it more challenging to provide a good quality and person-centred PBS service; an observation that is echoed in the disability services industry.

The process for the authorisation, monitoring and reporting of restrictive practices continues to vary across states and sectors. As a multi-state provider and with service delivery across the Education and Disability sectors, Aspect is required to implement and maintain different processes to comply with its legal responsibilities. In order to assist with this Aspect has developed a number of internal resources to assist staff in identifying and adhering to the various compliance requirements. In addition, the changing landscape with the roll out of the NDIS has required the suite of documents to be frequently reviewed as States have introduced new and changed legislation causing confusion for staff who must adapt to the frequent changes.

c) *Capable environments*

PBS focusses on the context in which challenging behaviour occurs. There has been increasing interest and research in developing 'capable environments'. Capable environments are those that support a person effectively and provide the optimal setting to support positive interactions and opportunities (McGill et al., in press). Capable environments include a range of strategies such as positive social interactions, support for communication, and support for participation in meaningful activities (see Attachment 1: Capable Environments).

Studies conducted have supported this approach, for example McGill *et al* (2018) completed a random control trial which implemented capable environments via setting-wide PBS which demonstrated significant reductions in challenging behaviour.

d) *Including people in their PBS service*

In general, people are often not included in developing their PBS service or plan, are not asked to give consent to a service, or have not been provided with information on how to contribute to or review their PBS strategies. This has been largely influenced by the medical model of disability, where the clinical 'experts' determine what supports should be 'done 'to' the people with disability.

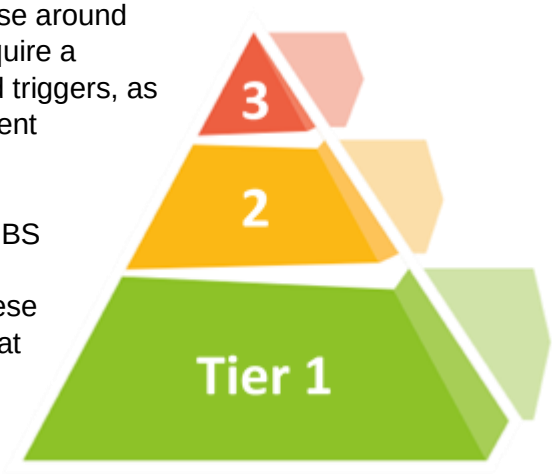
Increasingly, under human rights influenced PBS models focusing on choice and control, there is an expectation that people with disability are consulted and included in the restrictive practice authorisation process part of their application and support plan. This has been observed in practice to be the exception, rather than the rule.

e) *A Tiered approach*

PBS is an approach that has multiple levels or 'tiers' of support'. This includes proactive and preventative capable environments for all people with disabilities as being the key to

ensuring behaviours of concern are less likely, and reducing the need for restrictive practices (Tier 1 supports).

People with disability whose behaviours may challenge those around them, despite implementation of capable environments, require a specific PBS plan to address specific setting conditions and triggers, as well as teaching skills and functionally equivalent replacement behaviours (Tier 2 supports).



Despite the implementation of capable environments and PBS plans, some behaviours of concern may persist for a small number of people with disability. It is recommended that these individuals access a more tailored and intensive service, that can provide multi-elemental and comprehensive supports for the team. This approach is traditionally associated with "complex situation support" (Tier 3 supports).

In using a tiered approach to PBS people with disability can access individualised, positive and proactive support that meets their needs across a range of settings. It ensures and supports the reduction in the use of restrictive practices.

f) A focus on good quality PBS plans

Good quality PBS plans that are multi-elemental, individualised and have appropriate "contextual fit" across settings are key to reducing and minimising the use of restrictive practices, and ensuring that restrictive practices are only implemented alongside positive and proactive supports that aim to increase the quality of life of the person with disability. From reading the person's plan it should be immediately identifiable who the person with disability is, their likes and dislikes, strengths, interests, characteristics and wishes. In addition the PBS plan should include a range of individualised proactive supports, a functional behaviour assessment, skill development, response strategies and it should consider the effects of restrictive practices, fading attempts as well as detailed descriptions of the conditions of their use. PBS plans should be subject to critical review and development by qualified PBS practitioners to ensure they contain best practice and individualised supports.

g) A strong focus on implementation and service quality

PBS and PBS plans are only as good as their implementation. A good plan that sits on a shelf is ineffective.

Good implementation includes:

- a collaborative approach where all stakeholders are involved in the development of the PBS plan and there is a measure of contextual fit (Albin *et al*,1996) used to evaluate collaboration;
- a simple plan which identifies key everyday strategies to be implemented,
- involving and training all stakeholders in the plan;
- real life coaching of the person, family and staff of the strategies in the plan; and
- data based monitoring and review of implementation and barriers to implementation.

The use of a Periodic Service Review in sites such as group homes and day programs has been shown to support consistent implementation (e.g. McGill *et al,* 2018, Lowe *et al*, 2016).

h) Repeated practical competency-based staff training

Staff understanding and competency in PBS can help to reduce the use of restrictive practices through "effective behaviour support and alternative means of addressing behaviours of concern" (Richardson, et al (2019).

O'Dwyer et al (2017) found that staff who understood the main components of PBS and reported using these in behaviour support plans were less likely to use restrictive interventions than staff who had not been provided this training.

Webber, Major, et al, (2017) found that staff understanding of the triggers and function of a challenging behaviour and vigilance in providing support early to prevent an escalation of behaviour was associated with restraint being rarely needed even though the person with a disability still showed behaviours of concern and had few ways to communicate their needs.

2. Restrictive practice reduction strategies

The Restraint Reduction Network has published Training Standards (Ridley & Leitch, 2019). The standards include information on a human rights approach, legislation, person-centred practices as well as pre-delivery, delivery, post-delivery and trainer standards.

There is strong support internationally for the use of six core strategies to reduce and eliminate unnecessary restrictive practices. These strategies were first developed in mental health settings as the NASMHPD Six Core Strategies for Reducing Seclusion and Restraint Use© (Huckshorn, 2004; SAMHSA, 2010) and have been further developed to include and adapt to disability settings through the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector (The National Framework). The National Framework is a helpful structure for organisations to drive cultural change, lead changes, monitor restrictive practice use and continually develop positive practices. A comparison of the original mental health core strategies and those illustrated in The National Framework has been illustrated in the table below.

	NASMHPD	The National Framework
Core Strategy 1	Leadership towards organisational change	Person-centred focus
Core Strategy 2	Use of data to inform practice	Leadership towards organisational change
Core Strategy 3	Workforce development	Use of data to inform practice
Core Strategy 4	Use of seclusion and restraint reduction tools	Workforce development
Core Strategy 5	Consumer roles in inpatient settings	Use within disability services of restraint and seclusion reduction tools
Core Strategy 6	Debriefing techniques	Debriefing and practice review

More work can be done by the sector to describe, define and lead by example with respect to fading restrictive practices and particularly those practices that are used routinely such as seat belt buckle guards, harnesses, body suits and prescribed medication.

3. Zero tolerance and targets for zero restrictive practice use

Aspect has concerns about the terms 'zero tolerance' and setting targets for zero restrictive practices. 'Zero tolerance' has often been associated with a simplistic approach to discipline that uses non-negotiable harsh punishments that has led to high rates of suspensions and expulsions, often disproportionately affecting students of colour and with disabilities (Skiba & Knesting, 2001). Attempts to entirely eliminate restrictive practices such as restraint and seclusion have resulted in an over-reliance on suspensions, expulsions and the use of reduced hours or activity restrictions for behaviours (Deloitte Access Economics, 2017; NSW Ombudsman, 2017); which are still forms of restraint (environmental restraint) and therefore a restrictive practice in its own right. The use of overreliance on environmental restraints to reduce other types of restrictive practices contradict the goal of this elimination target. It also highlights the complexity and nuance involved in understanding all the different types of restrictive practices, which are not rigid and concrete in all circumstances.

In Aspect's view there are some strong reasons why a zero tolerance restrictive practice target is unhelpful include:

- It is impractical. Life is infinitely complex. There are many unpredictable and uncontrollable elements that result in challenging behaviour that puts the person or others at risk of harm and which may require a restrictive practice to support the situation safely. There are many occasions where not using a restrictive practice represents a failure of duty of care to that person or others.

- A zero tolerance target may encourage a culture of non-engagement with restrictive practice processes and non-reporting of restrictive practice use. With a zero restrictive practice goal, every restrictive practice then becomes a failure and a problem for individual staff members or the disability organisation. This presents a risk that:
    - individual staff members from disability organisations may hide or fail to report the use of a restrictive practice for fear of 'making the service or organisation look bad' or for fear of disciplinary action; and

    - services refuse to accept students or participants with existing restrictive practices into the organisation resulting in exclusion and discrimination of those with complex care needs.

- It is likely that many environments, services, schools or organisations reporting no restrictive practice use are not reporting rather than not using restrictive practices. Higher restrictive practice use might be due to specific circumstances (the beginning of a school year with new students and major transitions occurring) or the fact that a service predominantly works in more challenging situations. A zero tolerance approach does not take this into consideration and may disproportionately impact on

certain organisations ability to maintain a safe environment for all without understanding the full context.

- Aspect acknowledges that greater scrutiny over medical practitioners and the use of chemical restraints with people with disability is warranted. However, there are concerns that medical practitioners may unnecessarily or incorrectly diagnose mental health conditions to ensure that the medications prescribed are therefore not considered "restrictive practices" but rather necessary medication to manage a mental health condition. This may be because of a culture of restrictive practices is considered "bad" or something to be completely eliminated e.g. in a zero tolerance environment. The difficulty with applying a "zero tolerance" approach is that practices may go underground and be underreported or not used safely.

It may cause uncertainty for organisation and their staff in terms of what they can do to keep everyone safe, including themselves, the person with disability engaging in behaviours of concern, and, potentially, other people with disability, members of the public or even preventing damage to the physical environment. There have been a historic number of media reported examples of situations where people with disability have been seriously injured because staff thought they were not able to intervene to keep people safe and have left that person to injure themselves to the point of permanent damage. Additionally, in Aspect's experience, even with positive behaviour support implementation for the person with disability, restrictive practice use has been required as a last resort to prevent further violence to other people with disability in Aspect's care.

The Aspect Practice Think Tank has considered this issue from their perspective of people on the autism spectrum, and they agree with the rationale behind Aspect's position on a zero restrictive practice use.

Section 2: Aspect's current approach to restrictive practice use and reduction within Aspect schools and services

Restrictive practices use within Aspect schools and services

Aspect commits to implementing the highest standard across all settings and continually improving our approach based on international guidelines and research. Aspect acknowledges that there is always room for improvement as the organisation is always learning how to translate best practice into practical implementation.

In addition to its commitment to human rights, Aspect has a duty of care to all students and participants. Aspect considers that in some situations, not using a restrictive practice may represent a failure to keep a person safe. It is important that duty of care to individuals with a disability as well as duty of care to others that interact with these individuals, informs the discussion around human rights and restrictive practices. It is important to identify the conditions under which restrictive practices are used and therefore the on-going monitoring which is required. Aspect continually works to try to ensure that any restrictive practice is only used as set out in a behaviour support plan which:

- has been considered clinically necessary and appropriate as a temporary safety measure;
- is used as a last resort, for the least possible amount of time and in the least restrictive way;
- is implemented only:
    - while skill development and environment changes are occurring for the person with disability;
    - on a time-limited, monitored and reviewed schedule; and
    - with sufficient training and implementation measures for the people with disability and their support network;
- includes a plan to fade the use of the practice as soon it is no longer necessary for the safety of the person with disability or others;
- contains the participant's consent if they are an adolescent or adult and the participant is able to make informed decisions about their supports;
- contains parent's or guardian's consent for use of the practice in accordance with the person's behaviour support plan and crisis support plan if the participant themselves is unable to give informed consent; and
- focuses on improving the life of the person with disability with as minimal impact on their human rights as possible.

Outside of a prescribed and authorised behaviour support plan, Aspect staff may use a restrictive practice in an emergency situation to safeguard a person with disability against imminent danger, where the risk of not using the restrictive practice is greater than the risk of using the practice. For example, in a situation where a person with disability at an Aspect program continuously hits and chases another person, Aspect staff would first attempt verbal and/or visual redirections to stop the behaviour and encourage the person being hit to move away to safety. If this is unsuccessful however, staff may have to intervene and use physical restraint to keep everyone safe.

Aspect considers unnecessary, prohibited or unsanctioned acts as forms of abuse, and not forms of restrictive practices.

Aspect also prohibits the punitive practices of psycho-social restraint such as over-correction and response cost due to the risks inherent in these strategies of escalating as opposed to managing challenging behaviour. There are also the inherent risks of negatively impacting relationships between the individual and their carer as well as the potential for misuse. Additionally, there is a wide availability of alternative approaches which are preferable to psycho-social restraint. This is further supported by the fact that psychosocial restraint does not fall under the principles of good PBS. "*The problem with this strategy is that it does not address the function or purpose as to why a person behaves or acts in a particular manner, or in that setting. As such, a direct support professional may not respond appropriately to the needs of the person or teach the person a socially appropriate 'replacement behaviour' so the existing behaviour will continue to be a "problem".*" (Webber et al., 2010).

This current and historical approach to the definition of restrictive and prohibited practices was also detailed in Aspect's previous submission to the Disability Royal Commission (paragraphs 114 and 115 of Aspect Response to NTG 00027, dated 23 June 2020).

Aspect has included the below case studies from its work in schools and disability services to demonstrate the appropriate temporary use of a prescribed restrictive practice as it meets the conditions outlined above. All names and identifying information have been changed to maintain confidentiality.

Case study 1 – Rahme*

Rahme is an autistic young man who lived with both parents and two siblings. Rahme engaged in complex behaviours that included smearing and eating faeces. This behaviour continued for a long time, leading to complications such as diarrhoea and other gastrointestinal issues and risks to his and others' health. Rahme's family have had multiple engagements with behaviour support clinicians, and have attempted to implement a range of strategies, however, they often find these difficult to implement due to Rahme's sibling who also has disabilities and support needs. Over the past few years Rahme's family has used a body suit to prevent his access to faeces. This restrictive practice meant that Rahme could go out into the community regularly and engage in a range of activities safely with his family, who otherwise would be unable to manage.

Over time Rahme's circumstances have become more complex and he has moved into supported living. The body suit was initially used under the guidance of a behaviour support practitioner and occupational therapist in a planned approach to prevent access to faeces. Alongside implementation of positive behaviour support strategies by trained disability support workers, and with a consistent toileting program, the use of the body suit was successfully faded after six months. *Therefore the temporary use of this restrictive practice enabled Rahme to learn new skills and to maintain access to important daily activities and environments.*

Case study 2 – Sam*

Sam is a 5 year old primary school student on the autism spectrum who lives at home with his parents and another sibling who is also on the autism spectrum. Preschool was difficult for Sam due to his limited communication skills - resulting in him exhibiting challenging behaviour (e.g. biting, hitting, kicking, screaming and crying) to communicate. This also meant Sam experienced difficulty in appropriately initiating play with his peers, sharing resources or participating in group experiences. A review of Sam's experiences showed

that at preschool his day was unstructured and Sam found it hard to know what to do. He also had never worn shoes which led to occasional foot injuries. He was also incontinent. When Sam began schooling in an autism-specific school Sam was supported to:

- participate in a range of structured environments, scheduled routines, clear boundaries and positive behaviour supports that were collaboratively implemented at home and school;
- follow prompting and social scripting to support him to understand expectations and social interactions, such as when to wear shoes, how to share and take turns as well as other class routines;
- use visual supports and scheduling for toilet training;
- partake in a communication program to increase his ability to communicate his wants and needs through a safe method of communication; and
- engage in structured play sessions with a speech pathologist and occupational therapist to teach early play skills with peers.

With regard to Sam's and other students' safety where communication is difficult for Sam and challenging behaviours are present, there are times Sam is encouraged to take a walk with a staff member in lieu of his scheduled timetable to a part of the playground where there is also a gate between the playground where Sam is with the teacher and the playground where all other students and teachers are, which can be temporarily closed. This is to prevent Sam and his peers from being in the same playground together when things become tense between him and his peers, and it also allows for teachers to support de-escalation in line with Sam's PBS plan whilst maintaining safety for all involved.

As these supports have been implemented at school, teachers have seen Sam's skills significantly improve. Sam now uses many words and gestures in his communication; wears shoes where required to be safe, appears calmer and engaged in learning, and is generally responsive to social scripting, timers and visuals in social situations. At home, Sam's parents are reporting an increased quality of life for Sam, including that they are finding experiences out in the community and holidays much more manageable. Sam has also begun engaging in jokes to make himself and others laugh, improving his social rapport with others.

With the increased use of structured supports and social skill development resulting in the decrease in these challenging behaviours, it is intended that the need for the environmental restraint at school will be faded, and eventually withdrawn as Sam's social communication skill development increases and other, less restrictive and proactive strategies can be engaged. *We believe this demonstrates that the temporary use of this restrictive practice has enabled Sam, his teachers and his peers to have safe access to education whilst significantly improving Sam's overall quality of life and skills.*

*Names and identifying information have been changed to protect confidentiality and privacy of those involved in the case studies.

Disability support services specific compliance

Aspect commits to all relevant national and state based legislation, guidelines and reporting requirements relating to our disability support services, including the NDIS Quality & Safeguards Commission, NSW FACS restrictive practices policies and framework, the Victorian Disability Act (2006) and the ACT Senior Practitioner Act (2018).

PBS plans within Aspect NDIS services that contain restrictive practices adhere to the NDIS (Restrictive Practices and Behaviour Support) Rules 2018 and are developed only by authorised behaviour support practitioners. All other behaviour support plans containing

restrictive practices within non-NDIS disability support services are developed in consultation with PBS leaders in relevant positions as well as the individuals relevant to the person with disability's support, including external psychologists, allied health professionals and medical teams where engaged.

Aspect schools specific compliance

Aspect schools operate in NSW and SA, and comply with the directions of NSW Education Standards Authority (NESA) and South Australia Education Standards Board (ESB) respectively.

Aspect schools are committed to maintaining a fair approach to the discipline of students. The process of investigating allegations regarding student's behaviours and decision making follow the principles of procedural fairness. Aspect's schools expressly prohibit the use of corporal punishment within Aspect's schools and services, and never sanction the administration of corporal punishment in external services or in the home environment.

Aspect schools have voluntarily adopted the restrictive practices panel authorisation model and the monitoring practices of the NSW disability industry administered by FACS NSW as a long-standing approach to support best practice and human rights awareness. All teachers and teachers' aides receive the same training as Aspect's disability support workers on positive behaviour support, crisis prevention (MAPA©), and safeguarding to ensure appropriate practices are in place.

All behaviour support plans containing restrictive practices within Aspect schools are developed in consultation with PBS leaders as well as the individuals relevant to the person with disability, such as external psychologists, allied health professionals and medical teams.

Restrictive practices reduction approach – Aspect-specific Six Core Elements

Aspect works in partnership with Autistic people to improve the quality of life of our students and participants. Our focus is on the continual development of positive proactive strategies to create environments that reduce challenges and prevent restrictive practice use. For this purpose Aspect employs both strategies of good practice disability support, and restrictive practices reduction methodology and has translated them into a single Aspect-specific framework of Six Core Elements (see Diagram 1). Further details on Aspect's approach have been provided under the relevant Element headings below.

Core Element 1 - The organisation has a restrictive practices policy that provides clear guidance (e.g. explains what is allowed and when; lists alternative strategies; explains the requirement for use of restrictive practice as a last resort; ensures support plans requirements are met)

Aspect uses a proactive, multi-tiered PBS approach in working with people in situations where there is challenging behaviour or behaviours of concern.

Aspect has a PBS and Restrictive Practice policy which is available on its website policy page. This policy was first developed in 2008, it is applied across all settings including education and is reviewed and updated annually in line with evidence informed practices. To support the identification of evidence based practices and the translation of research to

evidence informed practice, Aspect also operates the Aspect Research Centre for Autism Practice (ARCAP).

Aspect has developed a suite of forms and practices including the '5 point star profile' (based on the Autism Initiatives (UK) Five Point Star), and 'green', 'orange' and 'red forms' to assist staff and the public to implement tiered, proactive and individualised supports, a functional behaviour assessment, skill development, response strategies and consideration of the effects of restrictive practices, fading attempts and detailed description of the conditions of their use. The free to use information, training and forms on PBS and support plans is also available on Aspect's Positive Behaviour Support web page.
For example, the organisation's Safeguarding the People We Support Committee and the Restrictive Practice Governance Committee established a procedure to monitor the use of fences, locked doors and gates. This ensures that Aspect has a clear, risk managed and age appropriate approach to the use of fencing, locked doors and gates at physical sites that minimises the potential unintentional restrictive practice use and aimed to lessen locked doors across sites.

Another example is Aspect's calm spaces. Calm spaces is an autism-specific strategy where dedicated calming spaces are available for voluntary use to assist the people we support in their emotional regulation. Aspect has created clear directives and a procedure on requirements for calm spaces to ensure these spaces are not unintentionally or incorrectly used as restrictive practices. This includes a Calm Spaces Register and clear signage (see Attachment 2: Calm Spaces sign) as well as training for staff on the use of these spaces.

Core Element 2 - The organisation regularly trains and has workforce development on Positive Behaviour Support (PBS), restrictive practice and restraint using an accredited approach (e.g. MAPA©). This includes having refresher training; explaining the impact of restrictive practices; encourages emotional support and debriefing; and is for all staff.

Aspect is committed to a culture of continuous learning that builds capacity in their staff through regular ongoing and revisionary training to its staff on these matters. We continually invest in resourcing required to enable lead practitioners to build capacity within their staff through training, reflection, on the floor coaching and practice reviews.

Currently, Aspect has mandatory training for staff to promote good practice disability support. Examples include:

- All staff receive training, supervision / coaching on the Aspect Comprehensive Approach. The Aspect Comprehensive Approach is an organisation-wide approach to support people on the autism spectrum, their family and carers, encapsulating more than 50 years of Aspect's expertise in providing services to children, young people and adults on the autism spectrum. As a result of our continuous review of the evidence-based literature, the Aspect Comprehensive Approach currently includes eight elements. The elements are; Health & Wellbeing, Positive Behaviour Support, Structured Supports, Learning and Participation, Individual Planning, Family and Community Involvement, Transition and Inclusion, Specialist Collaboration.

  The five principles underpin the Aspect Comprehensive Approach are:
  - It is applicable to all people on the autism spectrum.

- Interventions support all areas of a person's development and are based on assessment of individual needs.
- The approach is a positive and supportive model acknowledging a person's strengths, interests and aspirations, rather than a deficit approach.
- The approach involves collaboration between people on the autism spectrum, parents/carers and professionals.
- The approach is based on ongoing reference to research and clinical literature.

- All student/participant-facing staff receive PBS training. This training gives an overview of positive strategies and supports to proactively support individuals living with disability. This training aims to reduce the need for restrictive interventions; and also summarises and introduces restrictive practice definitions and identification of restrictive practices to promote reduction and elimination wherever possible. PBS training is usually provided every two months in Aspect's disability services, and annually in Aspect schools as part of the professional development program across the organisation, to ensure new staff are immediately provided with training in PBS.

- All student/participant-facing staff complete mandatory crisis prevention training. This teaches and outlines alternative non-restrictive de-escalation techniques as well as highlighting that restrictive practices should only be used as a last resort and applied as part of a comprehensive positive behaviour support plan. This training also promotes the use of the least restrictive option when managing crisis situations. MAPA© is usually run every three months in Aspect's disability services, and annually in Aspect schools to train new employees. Staff must attend refresher training once a calendar year.

- All student/participant-facing staff receive 'Safeguarding the People We Support/Child Protection' training. This training is helps people understand the signs and symptoms of abuse, neglect and exploitation of children and adults, as well as to identify staff's responsibility to prevent, monitor and respond to such situations. This training also outlines an understanding of prohibited and restrictive practices. It must be completed within the first month of employment, and staff must refresh this training each calendar year.

- All staff receive Aspect Code of Conduct training. Aspect's Code of Conduct training, which includes professional responsibilities, conduct around restrictive and prohibited practices, and the safeguarding of the people Aspect supports against abuse, neglect, and exploitation. This training is part of Aspect's induction process, and is provided as a refresher every two years.

- NDIS services staff are required to complete the NDIS Quality & Safeguards Commission Worker Orientation Module 'Quality, Safety and You' training, which includes the NDIS Code of Conduct. This training outlines and ensures staff are aware of and committed to reducing and eliminating unnecessary restrictive practices.

In addition to these standards of development and training, the implementation of PBS and Safeguarding practice leaders with entrenched responsibilities in established roles and dedicated positions is key to developing the workforce's understanding and use of restrictive

practices. Practice Leaders ensure practical support and continued development for staff, to achieve minimal restrictive practice use for people with disability.

While mandatory staff debriefs occur after every incidence of restrictive practice use as part of the investigation and improvement processes, Aspect is currently working on improving its staff debriefing support program. The Restrictive Practices Governance Committee is reviewing how the PBS three tiered framework can be put into place as a staff support and as part of good practice PBS (Gore & Baker, 2019). This work will expand on the already well established staff supports within Aspect to increase the amount and type of post-incident support.

Core Element 3 - All students / participants requiring behaviour support have developed strong support plans that are individualised, meet good PBS criteria and are developmentally appropriate.

PBS plans are an essential document that collates, structures and integrates PBS for an individual. There are evidence based guides for reviewing the content of effective plans e.g. 'Behaviour Support Plan Quality Evaluation' scoring guide II (BSP-QEII) (McVilly *et al*, 2012). It is important that plans meet these criteria if they are to be effective.

When restrictive practices are part of a planned response to keep people safe, they should be used as part of a positive behaviour support plan that includes:

- facilitation and development of a high quality support environment that is responsive to individual needs.
- functional behaviour assessment including consideration of the context, triggers, risk assessment, identification of potential strategies for responding to behaviour; and
- implementation, monitoring and regular review of the plan to evaluate their effectiveness.

At Aspect, PBS plans are written by authorised behaviour support practitioners within Aspect Therapy (a division of Aspect which provides certain disability services) in NDIS services, and by relevant staff in consultation with an individual's support team in Aspect's schools and other services. This is achieved with a combination of environmental assessment, functional behaviour assessment, crisis response planning and implementation supports to develop plans that are multi-elemental and person centred. As part of this process, behaviour support practitioners and relevant school/service staff engage with the student/participant, their family and support network in their home, community settings, school or other appropriate settings. These behaviour support plans will identify a range of strategies to proactively manage behaviours and support people with disability, as well as supportive strategies to be tried before implementing the restrictive practice. When including a restrictive practice in a behaviour support plan the practitioner or plan author must:

- reduce and eliminate the need to use a regulated restrictive practice for the participant;
- take into account any previous behaviour support assessments and other relevant assessments;
- change the participant's environment to reduce or remove the need for the use of regulated restrictive practices; and

- consult with the participant, the participant's family, carers, guardian or other relevant person as consented to and any registered NDIS provider who may use the regulated restrictive practice and other relevant specialists, as consented to.

Any NDIS participant PBS plan that contains restrictive practices which Aspect may need to implement are subjected to additional external oversight and monitoring as explained below.

PBS plans containing restrictive practices in Aspect's NSW services are submitted to the NDIS Commission, and are also taken to the NSW Family and Community Services (FACS) Restrictive Practices Authorisation Panel for approval. The plan is reviewed by the FACS Restrictive Practices Authorisation Panel, which includes service managers, behaviour support specialists and an independent from an external organisation. Any use of restrictive practices in line with the behaviour support plan are reported to the NDIS Commission.

PBS plans with restrictive practices implemented in Victoria are submitted to the Office of the Senior Practitioner and reviewed and authorised by the Senior Practitioner for additional external oversight and monitoring via the Restrictive Intervention Data System (RIDS). Furthermore, plans containing restrictive practices are submitted to the NDIS Quality & Safeguards Commission. Any use of restrictive practices in line with the behaviour support plan are reported to the Senior Practitioner and the NDIS Commission.

Core Element 4 - The organisation has strong leadership based on rights, values and person centeredness. The leadership conducts data reviews to continually improve practice

Aspect endeavours to understand, engage and celebrate the strengths, interests and aspirations of people on the autism spectrum. This includes an organisational culture and a plan that respects and understands disability and diversity, and explicitly ensures that all environments are welcoming and accommodating.

Aspect recently published a Disability Access and Inclusion Plan (2020-2023) as part of a broader approach to diversity and inclusion. This culture seeks to reduce restrictive practice use as it promotes a person's autonomy, it seeks to understand and respect differences in behaviour, and encourages people to communicate. It includes a trauma informed approach as it is probable that Aspect supports more students and participants who have experienced chronic, complex trauma than the students within the "mainstream" school environment, due research indicating persons with autism are more likely to suffer trauma (Kildahl *et al*, 2020).

Aspect has established leadership positions across all Aspect disability support services and schools to lead safeguarding and positive behaviour support practices in its commitment to the reduction and elimination of restrictive practices where possible. Safeguarding and PBS practice leaders are responsible for supporting staff to implement behaviour support plans, training and supporting staff development in the areas of PBS and safeguarding as well as providing on-the-floor coaching, modelling and consultation.

Aspect has implemented a process across its services that reflects the various state based legal and policy requirements and includes the allocation of significant resources, both human and technical to meet these requirements. This is not directly funded by the relevant funding bodies. For example, Aspect has a PBS & Restrictive Practices Governance Committee which reports to the Aspect Executive and Board. The PBS & Restrictive Practices Governance Committee was established to strengthen the safeguards for people

receiving support and to demonstrate a clear commitment to the reduction of restrictive practices use. The committee's terms of reference include the monitoring of actions under Aspect's Six Core Elements to reduce and eliminate restrictive practice wherever possible through restrictive practice reduction strategies. The committee works to continually improve Aspect's approach. In 2020 Aspect has focused on defining and improving two areas of practice - openness and inclusion of people in the restrictive practice and staff wellbeing. The committee is also reviewing the use of unauthorised restrictive practices across Aspect.

Aspect wants to continue to build a rigorous culture of reporting that identifies all unauthorised restrictive practice and seeks to clarify where staff development is required. It is important to understand the full context of any restrictive practice use, but particularly where an unauthorised restrictive practice is used. The unauthorised use may have been to prevent a possible serious injury or life threatening situation, or there may present an opportunity for improvement and development in the context of good PBS. Through Aspect's leadership, consultation with all stakeholders and frequent reviews of its own data, Aspect will continue to improve its practice of and reduce any unnecessary occurrences of, restrictive practices.

Leadership reviews on restrictive practices use also occur through Aspect's restrictive practices authorisation panels, and regular designated meetings. Within Aspect's Independent and Community Services, this takes place as monthly Quality and Safeguarding meetings to analyse incident reporting and data analysis, and determine clear actions around the use of restrictive practices in the services. These meetings aim to improve and develop PBS and safeguarding practices across Aspect disability services. Within Aspect schools, these reviews take place both at the local school level, and across Aspect Education within the leadership of all nine Aspect schools and education executive.

It is in Aspect's experience that diligent adherence to restrictive practice monitoring results in the fading of restrictive practices use. As people engage with review panels and on-line state based mechanisms (e.g. FACS Restrictive Practices Authorisation Portal, Victoria's RIDS system), there is continued momentum and impetus to complete work to a high standard. Ongoing reviews of practice mean that positive strategies replace restrictive practices wherever and as soon as possible.

Core Element 5 - The organisation is open and transparent, including all stakeholders

Aspect shares key policies openly on our website. Aspect also makes several fact sheets on PBS and its approach to restrictive practices available on the Fact Sheets webpage.

Aspect adheres to ongoing restrictive practice monitoring and authorisation processes as required by the relevant national and state authority for disability services, which includes comprehensive reporting on authorised and unauthorised or emergency uses of restrictive practices. These processes were implemented prior to, and have been modified following, the roll out of the NDIS Commission and the NDIS (Restrictive Practices and Behaviour Support) Rules 2018 in each State. This means that all NDIS service applications for restricted practices are review by the Quality and Safeguarding Commission as well as relevant state based authorities.

Aspect has developed a framework for the inclusion of people with disability in their PBS service. Each part of the framework collates available research, international best practice

and Aspect's own work and is co-produced, researched, delivered and reviewed in partnership with Autistic people. This includes currently conducting research into School-Wide PBS practices. Aspect is working to include participants and students in their PBS services and in restrictive practice processes as much as possible. Many people with disabilities have the ability for decision making and consent in either a full or supported capacity, and so are able to refuse or give time-limited consent to restrictive practices. Where this is not possible, or parent/guardian consent is required, substitute decision makers are engaged to refute or give the consent.

Parents, carers and (where appropriate) guardians are involved in all of Aspect's work. Parents or a person's circle of support (including health and medical professionals) are also included as soon as any challenges arise to work together to develop appropriate PBS responses. Parents/guardians are requested to sign time-limited consents to every restrictive practice where the person with disability is unable to consent due to their age or a cognitive disability.

Each consent obtained is within the context of the full PBS plan, which the person Aspect supports and/or their parent/guardian also consents to. It is inclusive of crisis support functions and clear instruction for where the restrictive practice may only be used as a last resort, in line with appropriate trained strategies and adequate support for the person with disability.

Every use of a restrictive practice, whether authorised or used in response to an emergency situation, is documented as part of Aspect's incident reporting processes. These incidents are discussed with the people we support through debriefing, as well as families / circles of support where appropriate. Families, circles of support and the people we support are encouraged to provide feedback and/or complaints about the management of incidents through Aspect's Feedback and Complaints system. Aspect's incident management process is integral to its continued review and evaluation of restrictive practice so that we may continuously improve. Consolidated reports are reviewed by Aspect management and relevant committees to identify systemic improvements and areas of further development. Where a restrictive practice is authorised it is monitored and all uses reported to the relevant restrictive practices authorisation panel in Aspect's disability or education services, to support the Authorisation Panel review processes of the restrictive practice use.

As part of Aspect's commitment to being open and transparent, Aspect recently worked with the Autistic Self Advocacy Network Australia and New Zealand (ASAN AUNZ) to develop its Disability Access and Inclusion Plan (2020-2023). Within this plan and the work completed by ASAN included a review of Aspect's restrictive practices approach. Actions have been included in the DAIP, as well as a fact sheet on why Aspect does not have a zero restrictive practices goal, that has been published on our website.

Core Element 6 - The organisation has and uses a range of restrictive practices reduction tools and strategies.

Aspect uses a range of evidence-based restrictive practice reduction tools and strategies and continually reviews practice to improve performance. These include:

- Setting reviews - Aspect regularly considers environmental changes to its sites to decrease unnecessary uses of environmental restraints, including moving services out

of closed physical sites to "hub" and community based programs that are more suitable for participant needs.

- Crisis reviews - Deveau & Leach (2015) demonstrated that the use of post restraint reduction meetings maybe a useful component of holistic restraint reduction. Aspect uses a restrictive practice checklist to review crisis situation, being a situation where a high level restrictive practice of a physical restraint, PRN chemical restraint or seclusion has been used. The questions are designed to prompt reflection of good practice in terms of restraint implementation, and are built into Aspect's incident report form. Managers and supervisors at Aspect are responsible for going through this checklist with their staff involved in the incident.

The questions used aim to help staff reflect on whether the restrictive practice was used as a last resort, whether it was reasonable and proportionate, whether it protected the dignity of the individual and how information from the incident can be used to proactively support behaviour in the future. Staff reflection and debrief after incidents are critical to managing and supporting change in attitude and restraint use culture. When staff reflection and debrief is completed well, the hope is that restraint use will be reduced in turn, as proactive and positive strategies are implemented effectively.

Conclusion

The current disability climate in regards to restrictive practices is complex. Duty of care for an individual person requires the protection of their human rights which includes the freedom from violence and abuse. Sometimes, due to competing demands to protect and ensure the safety of all people involved in a situation, a restrictive practice is required as a last resort. To ensure the last resort use and to protect individuals subjected to such practices from misuse, abuse and harm, Aspect believes that a national independent body specifically focused on best practice and external to organisations and across industries should be established, using the best available model, and that has oversight for the authorisation, monitoring and review of restrictive practices use and processes. Additionally, Aspect believes that a regulatory framework should be implemented that is consistent across states and between sectors that addresses the rights of individuals with disability and the obligations of service providers with respect to restrictive practices.

Currently there are multiple and complicated authorisation processes for the use and reporting of restrictive practices across states/territories and national bodies for disability services. At times due to compliance, "ticking boxes" and meeting timeframes Aspect is concerned that the person with disability subject to the restrictive practice is not considered at the forefront of these processes. In other sectors there is little or no oversight. Aspect works in two sectors that have this stark contrast – disability services and education.

The disability services sector is an ever-changing landscape of compliance as the NDIS Quality & Safeguards Commission rules have come into effect in each state. Some processes (such as those implemented in the ACT) involve a 'PBS Panel' rather than 'restrictive practices authorisation process' with aim to ensure the person with disability and their support network is included, and the focus on positive and proactive strategies has been positive. Other states/territories have implemented processes with some success, but

overwhelmingly with confusion and inconsistency both for participants and implementing providers.

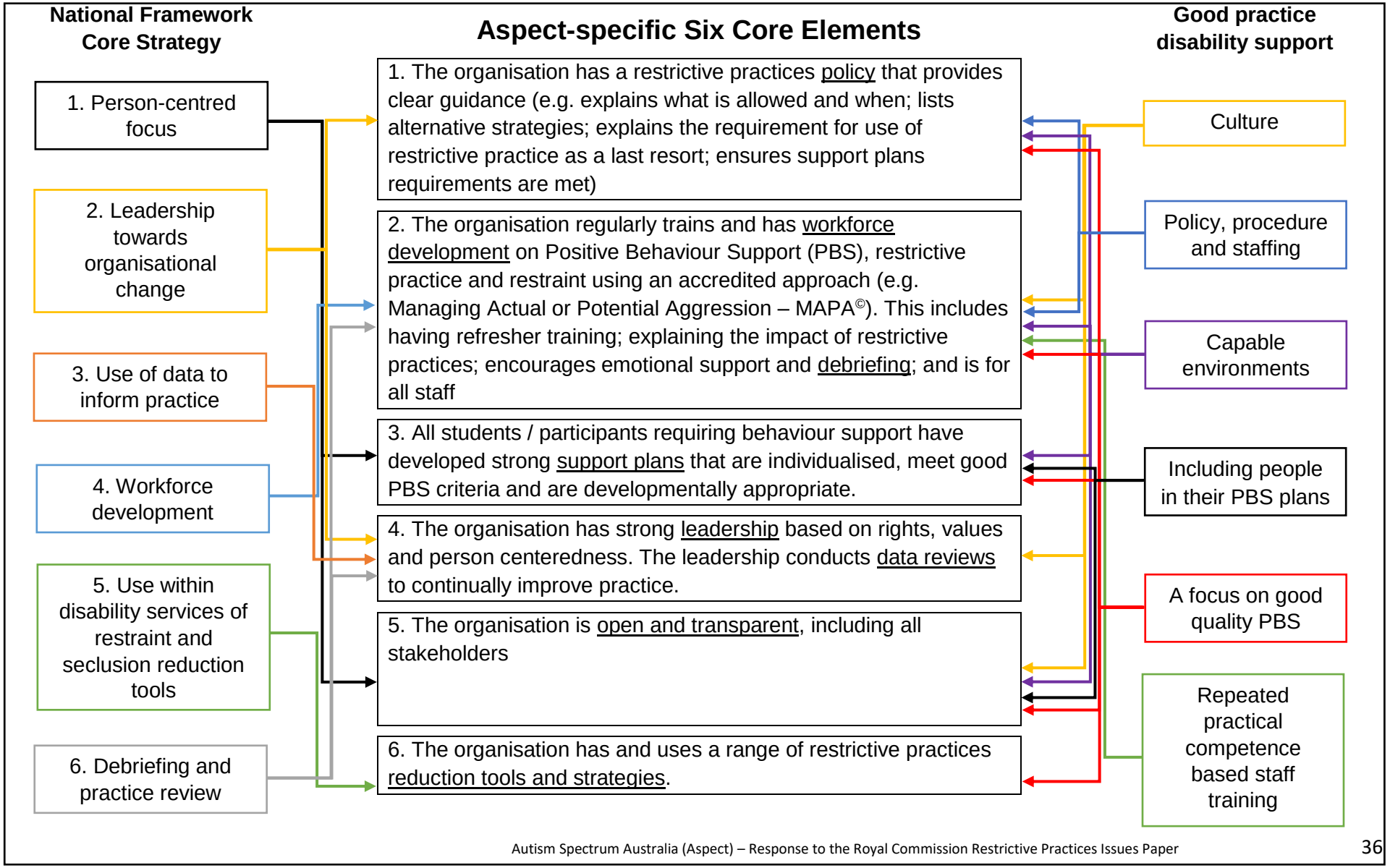
Within education, there are no regulatory oversight processes in the two states where Aspect operates schools – NSW and SA. The inclusion of education settings in restrictive practice authorisation and implementation in the ACT has been welcomed and will ensure consistency, oversight and transparency across settings in that jurisdiction. Aspect believes a similar approach to restrictive practices oversight in education in all states/territories would be valuable.

Ultimately, inconsistent complex approaches to monitoring restrictive practices with high administrative burdens contribute to an inefficient and ineffective approach. A consistent national approach to defining and monitoring restrictive practices will benefit everyone, with a broadened approach to include support and information for families, education settings, medical and health environments as well as disability specific services.

Aspect would welcome the opportunity to discuss this Issues Paper response further.

30 September 2020

Diagram 1: Aspect-specific Six Core Elements



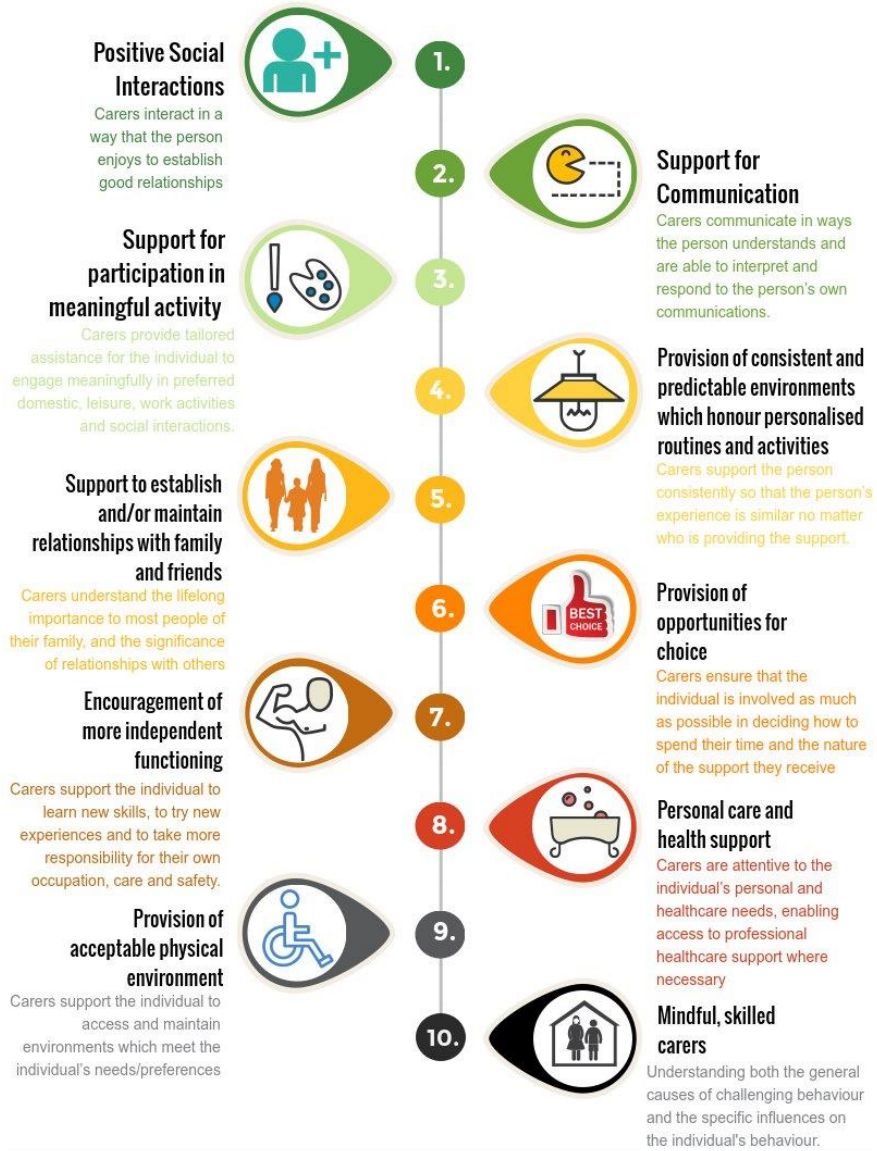
Attachment 1: Capable Environments

(image sourced: https://pbs.twimg.com/media/Cg9jkkdW4AEHzEH?format=jpg&name=large)

Capable Environments

Challenging behaviour remains a significant problem in family and supported accommodation settings for people with intellectual and developmental disabilities (Department of Health, 2007). Adapting the environment that people with IDD live in, is a supportive way to minimise behaviours that challenge and improve the quality of life for individuals, families and carers. Foundational values of positive behaviour support believe in fixing the environment, not the person. These suggestions help us understand how we can best meet the needs of those with IDD and CB.

A summary of 'Capable Environments' by McGill, Bradshaw, Smyth, Hurman & Roy.



Effective Management and Support

Carers are managed and/or supported by individuals with administrative competence and the skills to lead all aspects of capable practice.

Effective Organisational Context

Support provided by carers is delivered and arranged within a broader understanding of challenging behaviour that recognise the need to ensure safety and quality of care for both individuals and carers.

FULL ARTICLE

http://www.kcl.ac.uk/sspp/policy-institute/scwru/news/2014/newsfolder/McGill-et-al-Capable-environments.pdf

CREATED BY

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Attachment 2: Aspect Calm Space Sign

Calm Space

This space is only for people to go willingly to allow themselves to calm and manage their emotions as part of an emotional management or Positive Behaviour Support approach.

There should be **no** mechanism for keeping people in this space against their will (no lock or outside zip or fastener).

- Any person should be able to leave freely (at any time) and should be taught that this is the case.
- The space should be designed to meet the needs of a person based on a consultation with the person and their family as much as is possible.
- Where the person is not able to communicate their preferences, minimum requirements* for the design of a withdrawal space need to be met.
- If the person shows any signs of upset and distress caused by being in the calming space (not because of what happened beforehand), log an incident report via RiskMan and implement recommended support strategies.

*Minimum requirements: the environment needs to be sensory friendly and to facilitate calming i.e. not to dark or bright to cause discomfort, opportunities to access soft materials (cushion), sufficient room so that movement is not restricted but supporting a person to feel private, safe and secure, support easy access to drink and toilet, ideally with visual supports to promote calming strategies)

The sort of visuals that might be included in the space are to support emotional regulation and give clear instruction about the behavioural expectations of the space.

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