



# Restrictive Practices Guidelines



Government  
of South Australia



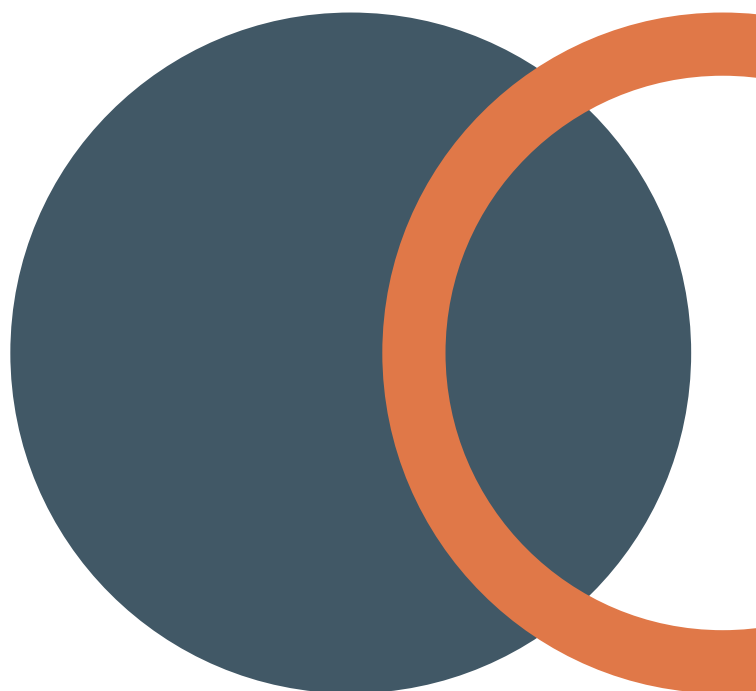
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**All South Australians have the right to a life that is meaningful, self-determined and connected with the people and communities around them.**

**When communities are inclusive and fair, people with disability can participate and contribute on the same basis as all others. Restrictive practices are any interventions that restrict the rights and freedoms of a person, with the goal to protect that person or others from harm. People with disability are more likely to experience restrictive practices than other members of the community.**

Restrictive practices can be a serious breach of human rights. The South Australian government is committed to upholding the rights of people with disability, as enshrined in the United Nations Convention on the Rights of Persons with Disabilities 2006 and the Disability Inclusion Act 2018.

Along with state, territory and national counterparts, the South Australian government has endorsed the National Framework for Reducing and Eliminating Restrictive Practices in the Disability Sector 2013 ('the National Framework') and the National Principles for the Authorisation of Restrictive Practices ('the National Principles'). This national approach ensures that people with disability have access to the same protections regardless of where they live.

The authorisation scheme established by Part 6A of the Disability Inclusion Act 2018 sets out the roles, processes, and criteria for the authorisation of restrictive practices by registered NDIS providers for NDIS participants in South Australia. Accountability, transparency, and visibility of restrictive practices are an important step in reducing their use. But it is only one step.

The Restrictive Practices Guidelines provide further details about the operation of the authorisation scheme. It situates the process of authorisation within a broader context of person-centred practice, education and awareness, and systems improvement that is most likely to prevent and reduce the use of restrictive practices over time.



# Legislative Context

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## International human rights conventions

The United Nations Convention on the Rights of Persons with Disabilities ('the CRPD') was adopted in 2006, and Australia was one of the first countries to ratify this convention. The CRPD promotes, protects, and ensures 'the full and equal enjoyment of all human rights and freedoms by all persons with disabilities, and to promote respect for their inherent dignity'.

Relevant to the issue of restrictive practices, the CRPD articulates people with disability's rights to:

- Respect for their inherent dignity, individual autonomy including the freedom to make their own choices, and independence of person (Article 3).
- Equal recognition before the law (Article 12)
- Liberty and security of their person (Article 14)
- Freedom from cruel, inhuman, or degrading treatment or punishment (Article 15)
- Freedom from exploitation, violence, and abuse (Article 16)
- Right to physical and mental integrity (Article 17)
- Personal mobility (Article 20).

The CRPD provides a human rights framework that guides the operation, interpretation and oversight of the authorisation scheme.

## National legislation

The South Australian NDIS restrictive practices authorisation scheme is situated within the context of Commonwealth legislation, specifically:

- The National Disability Insurance Scheme Act 2013, which establishes the National Disability Insurance Scheme (NDIS), the National Disability Insurance Agency (NDIA) and the NDIS Quality and Safeguards Commission (NDIS Commission). The NDIS Quality and Safeguards Commissioner's behaviour support function is to provide leadership in relation to behaviour support, and in the reduction and elimination of the use of restrictive practices by NDIS providers.
- The National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018, which set out some of the conditions that providers must comply with to become and remain registered NDIS providers. It also sets out the NDIS Practice Standards that apply to all registered NDIS providers, and those that apply to providers delivering more complex services such as behaviour support.
- The National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 which establish the conditions of registration for registered NDIS providers who use regulated restrictive practices in the course of delivering NDIS supports. The Rules also establish the requirement to develop a behaviour support plan and report on the use of regulated restrictive practices.
- The National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018 which establish the requirements to notify the NDIS

Commission of reportable incidents, including the use of unauthorised restrictive practices.

- The National Disability Insurance Scheme (Code of Conduct) Rules 2018 sets out the NDIS Code of Conduct, which supports the rights of people with disability in the NDIS to have access to safe and ethical supports.

The national legislation, practice guidance and directions issued by the NDIS Commission establishes responsibilities and obligations on registered NDIS providers delivering supports for people with disability in the NDIS. Nothing in the South Australian authorisation scheme derogates from these responsibilities and obligations. Registered NDIS providers must ensure compliance with both national and state requirements.

## State legislation

The Disability Inclusion Act 2018 (as amended by the Disability Inclusion (Restrictive Practices - NDIS) Amendment Act 2021) establishes the legislative framework for the authorisation of restrictive practices by registered NDIS providers for NDIS participants in South Australia. The authorisation scheme supports the objects of the Act (section 8) in 'providing safeguards in relation to the delivery of all supports and services for people with disability'.

The Act, the Disability Inclusion (Restrictive Practices - NDIS) Regulations 2021 and the Restrictive Practices Guidelines 2021 must be considered in their entirety. These foundational requirements will also be supplemented by fact sheets, templates, and procedures for registered NDIS providers, people with disability, and others.

# Practice Context

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The restrictive practices authorisation scheme operates within the context of skilled and effective practice that is characterised by the following elements:

## Positive Behaviour Support

Positive behaviour support is an evidence-based framework for assessment, planning and intervention that focuses on addressing a person's needs to increase their quality of life and reduce behaviours of concern. Positive behaviour support involves working with the person, their family, carers and professionals to develop a shared understanding of behaviour, the needs that the behaviour is communicating, and the supports that are required to meet those needs in a positive way.

Positive behaviour support has a number of key components:

- **A person-centred approach** that is focused on the person with disability's needs, goals, wishes and perspectives. Person-centred approaches respect the person's dignity, autonomy and right to make decisions for themselves so that they can live meaningful and satisfying lives.
- **Partnership** with the person with disability, their family, carers and support professionals. Positive behaviour support recognises that behaviour occurs in the context of the person, their environment, and the relationships around them. Positive change can only occur when there is a shared understanding of behaviour and unmet needs, and a strengths-based approach to building the capacity that is needed to support the person. A partnership approach ensures that people with disability, their family, carers,

support workers and other professionals are consulted and are able to contribute to the behaviour supports provided.

- **Evidence-based intervention** based on functional behaviour assessments. Examining when, where, why and what behaviour occurs, its antecedents and consequences, and the role of physical and social environments are central to reducing behaviours of concern. Behaviour support plans consolidate the assessment and interventions in a way that help the person with disability, their families, carers and professionals to support them in an agreed and consistent way.
- **Skills development**, where people with disability are supported to learn, practice and embed new skills and functionally equivalent replacement behaviours that allow them to meet their needs in a safe and positive way.
- **Ongoing monitoring and review.** Positive behaviour support is not a static process, but is continually being reviewed for progress towards behaviour goals and adjusted in light of emerging needs and increasing capacity. The documentation of this review process allows people with disability, their families, carers and professionals to form a shared understanding of their progress towards eliminating restrictive practices.

Restrictive practices can only be authorised when they are consistent with, and are supported by, a behaviour support plan established within this framework. Restrictive practices that are not authorised may constitute an assault or a tortious act against a person with disability.



## Continuum of responses

Restrictive practices are a reactive, time-limited intervention intended to provide safety as a last resort when no other strategy is effective or appropriate. Restrictive practices must be situated within a continuum of supports for a person with disability that includes:

- **Preventive strategies** that promote quality of life and reduce the unmet needs that give rise to behaviours of concern. These include adjustments to the person's:
  - environment that increase predictability, accessibility, and comfort
  - routines that provide opportunities for recreation, stimulation, and social interactions
  - ways of engagement that support participation and decision-making at the level that the person with disability feels most comfortable
- **Early intervention** when there are indicators that needs are not being met. Early intervention relies on understanding a person's individual signs of unmet needs which may be more subtle than behaviours of concern, and providing opportunities for targeted support, connection, and care.
- **Reactive strategies** to redirect, intervene and minimise behaviours before the use of restrictive practices.

## Relationship-based practice

Behaviour support (including restrictive practices) must be undertaken within a safe, trusting, and respectful relationship between the person with disability and their support workers. The use of restrictive practices (particularly physical restraint and seclusion) may cause ruptures in this relationship, for people who are the subject of the restrictive

practice, those who apply the practice, and others who may witness or are indirectly affected by it. Debriefing and restorative actions are essential to ensuring that these ruptures are acknowledged and repaired, so that they do not compromise the ongoing relationship between people with disability and their support workers.

Relationship-based practice is especially important in the context of people with disability often having large numbers of family members, carers, and professionals who form their support network. Positive, trusting, and respectful relationships between these people are essential to providing consistent and seamless care that places the person with disability at the centre.

## Trauma-informed practice

Trauma occurs when a person experiences stress that overwhelms their body's capacity to cope. Restrictive practices (particularly physical restraint and seclusion) may constitute a trauma when they occur in the context of ongoing relationships, involve multiple incidents over time or a significant once-off event, and are associated with feelings of stigma and shame by the person who is restricted.

Restrictive practices may also compound the effects of past trauma including experiences of abuse and neglect, family violence, intergenerational trauma, and restrictive practices in different settings (child protection, justice and corrections, aged care, mental health). There is a high prevalence of trauma experiences among people with disability, and this prevalence is higher for people with disability who are Aboriginal, from culturally and linguistically diverse backgrounds, women, or who have a mental health condition.



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A trauma-informed approach recognises this prevalence of trauma, how it affects a person's experiences of restrictive practices, and the importance of not re-traumatising the person.

Trauma-informed approaches also recognise that a person's cognitive capacity can fluctuate depending on their emotional, psychological, and physical state. This means that a person with disability may be able to use language and reasoning

to make informed decisions for themselves when they feel calm, regulated, safe and supported but may not be able to do so in a heightened state of distress. They may not be able to remember what happened during a behaviour emergency and may need support to remember and understand why service providers may have responded in a particular way. Trauma-informed approaches are premised on unconditional positive regard for the person at all times.

While the traumatic impact of physical restraint and seclusion may be readily understood, the cumulative impact of other restrictive practices such as environmental restraints should not be underestimated. People with disability have highlighted the emotional complexity of restrictive practices, and its impact on their sense of agency and quality of life.

Trauma-informed responses to restrictive practices emphasise the importance of debriefing shortly after critical incidents, and providing supports to address the impact of restrictive practices, including:

- physical impacts (such as weight gain, headache, constipation, sexual dysfunction, dry mouth, low blood pressure, and insomnia)
- mental impacts (such as anxiety, distress, learned helplessness, hypervigilance, and depression)
- social and relational impacts (such as avoidance, clinginess, mistrust, and withdrawal).





## Cultural safety and competence

The effective use of restrictive practices must be situated in a broader understanding of the impact of systemic racism, colonisation and the exercise of the state authority for Aboriginal and Torres Strait Islander people and some people from culturally and linguistically diverse backgrounds. Aboriginal and culturally diverse people who have had these experiences directly or indirectly are less likely to experience restrictive practices as a protective measure that supports their safety.

Aboriginal people and people from culturally and linguistically diverse backgrounds may also have different conceptualisations of behaviours of concern and what is required to support positive behaviours. What may be seen as behaviours of concern may reflect broader needs for an Aboriginal person with disability to be connected with culture, country and land which can be challenging in residential disability settings.

Culturally safe and competent practice requires working with the person with disability, their family, carers and people with cultural authority. It is important to understand how behaviours and unmet needs should be considered, by whom, and the supports that are required to support the person with disability to be well within themselves.

## Service improvement

The use of restrictive practices must occur within a context of ongoing service improvement in organisations to ensure high quality supports and services. This involves:

- Ensuring that organisations have policies, procedures and practices that comply with national and state laws, policies, and guidelines.
- Reflective practice, supervision, and ongoing professional development for staff to create an organisational culture against the use of restrictive practices
- The evaluation of data about behaviours of concern and the authorisation and use of restrictive practices to inform systems improvement.

**Culturally safe and competent practice requires working with the person with disability, their family, carers and people with cultural authority.**

# Practice Principles

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## Human rights, dignity and respect

People with disability have a right to the full and equal enjoyment of all human rights and fundamental freedoms. Restrictive practices limit the freedom of movement, choice, and bodily integrity of people with disability. The limited use of restrictive practices must only occur when they are necessary to address a risk of harm that jeopardises the rights of the person with disability and others to be safe and fully participate and be included.

People with disability have a right to be treated with dignity and respect, and to have their identity, culture and diversity valued. This means being able to exercise choice and independence to the greatest extent possible about:

- their own care and the services they receive
- their relationship with family, friends, carers and others
- their participation in the community, including recreation and social activities.

People with disability must be encouraged and supported to participate at all stages in the service delivery. This includes contributing to the development of their behaviour support plan, providing informed consent (or informed refusal) to the use of restrictive practices, and contributing to decisions about restrictive practices.

## Safety

Restrictive practices should only be used to address safety issues arising from behaviours of concern. However, some restrictive practices may have safety implications for the person subject to the practice and for the

person implementing the practice. The use of restrictive practices may also introduce new behaviours of concern.

Risk assessments should be undertaken as part of the behaviour support planning process to:

- identify risks
- assess the severity and likelihood of these risks
- balance the risks arising from behaviours of concern and the risks that are introduced through the use of restrictive practices
- develop proportionate strategies to mitigate these risks.

As behaviour interventions take effect, the nature and degree of risk should change. Risk assessments should be reviewed regularly as part of the behaviour support planning process to ensure that they remain relevant and accurate.

Restrictive practices should not be used to address all risks, but only the risk of harm from behaviours of concerns that cannot be managed in a less restrictive way. Where possible, people with disability should be supported to understand and manage the daily risky choices that are made by all members of the community.

## Informed consent

While section 23M of the Disability Inclusion Act 2018 permits the use of restrictive practices without the consent of the person with disability, informed consent remains a core practice principle. People with disability are entitled to participate in decisions that affect them, to make informed choices about the behaviour supports that will be helpful in their circumstances, and to have their preferences taken into account and given practical effect wherever possible.

Many people with impaired decision-making capacity are able to make decisions about the use of restrictive practices for themselves and are able to recognise when they need support from workers, carers and family members to protect themselves and others from harm. Their informed consent (or refusal) for restrictive practices must be sought, considered and be influential in the authorisation decision. Supported decision making provides a best-practice framework to enable people with disability to exercise and enjoy these decision-making rights.

Where orders exist for substitute or alternative decision-makers, the views of these individuals about the use of restrictive practices for the person with disability should also be sought and documented for consideration in the authorisation decision.

Children and young people must be provided with support to make informed decisions about the use of restrictive practices in their care wherever possible. Their informed consent (or refusal) must be sought, considered and be influential in the authorisation decision if they have sufficient maturity to understand the nature and implications of using restrictive practices. To consider a child's competency to make informed decisions, registered NDIS providers must consider the child's:

- understanding of the relevant information
- ability to weigh up that information, including the benefits and risks for themselves and others
- ability to communicate their decision.

The informed consent (or refusal) of a person with disability about the use of restrictive practices in their care must be sought and documented as part of the behaviour support planning process and included in applications for authorisation of restrictive practices.

People with disability are able to make informed decisions to withdraw their consent about the use of restrictive practices, and this may occur for many reasons (eg. where their circumstances have changed, based on their experiences, changes in their perspective). Like informed consent, withdrawal of consent is informed when the person understands the nature of the decision they are making and the implications of the decision. Consent and withdrawal of consent may not be considered to be informed decisions if they are made when the person is distressed, emotionally escalated and experiencing a crisis. In these situations, registered providers must give priority to the decisions the person with disability has made when they were feeling safe, settled and supported.

## **Least restrictive and last resort**

Restrictive practices are considered to be an intervention of last resort in a limited number of circumstances where there is no reasonable alternative to protect a person with disability and others from behaviours of concern. Where restrictive practices are required, they must be proportionate to the negative consequences and risk of harm and apply the least amount of force for the least period of time.

The principle of “last resort” must be applied at two levels:

- The use of the behaviour support planning process to evaluate the use of preventative, early intervention and reactive strategies to address behaviours of concern to ensure that the use of restrictive practices is avoided where possible. The behaviour planning process should demonstrate that there have been reasonable and concerted efforts over

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time to support behaviour change, and why these have not been sufficient to secure safety.

- The stages of a behaviour incident for a person with disability must be understood, so that opportunities to prevent incidents, identify and respond to early signs of concerning behaviours, and redirect or minimise behaviours of concern before incidents escalate to the unsafe level where restrictive practices are required.

Authorised restrictive practices must be regularly reviewed to explore opportunities to practice new skills and trial incremental reductions in restriction.

Where restrictive practices are applied in shared residential settings, efforts must be made to reduce the impact on others living in the same house. This may include providing keys or access codes to other residents who do not require the same restrictive practices.

## **Transparency and accountability**

People with disability are entitled to equal treatment and equal protection under the law and are entitled to transparency and accountability in the decisions that are made about restrictive practices.

The authorisation scheme provides transparency and accountability in setting out:

- Who has the authority to make decisions about restrictive practices
- The criteria that must be used to make these decisions
- How decisions are communicated to people with disability, their family members, legal guardians, and registered NDIS providers

- How these decisions are implemented by registered NDIS providers
- The means of review and appeal
- Reporting requirements at an individual, organisational and government level.



Section 9 of the NDIS Act 2013 defines restrictive practices as ‘any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability’. Section 6 of the NDIS (Restrictive Practices and Behaviour Support) Rules 2018 defines regulated restrictive practices, and these definitions are mirrored in section 23B (1) of the Disability Inclusion Act 2018. The use of regulated restrictive practices must be undertaken in accordance with state authorisation processes and a behaviour support plan.

The NDIS (Restrictive Practices and Behaviour Support) Rules 2018 set out the minimum requirements for behaviour support plans developed by NDIS behaviour support practitioners. Specifically, Rule 21 states that the plan must include strategies that are evidence-based, person-centred and proactive and that address the person with disability’s needs and the functions of the behaviour. The regulated restrictive practice must:

- *‘be clearly identified in the behaviour support plan; and*
- *if the State or Territory in which the regulated restrictive practice is to be used has an authorisation process (however described) in relation to that practice—be authorised in accordance with that process; and*
- *be used only as a last resort in response to risk of harm to the person with disability or others, and after the provider has explored and applied evidence-based, person-centred and proactive strategies; and*
- *be the least restrictive response possible in the circumstances to ensure the safety of the person or others; and*
- *reduce the risk of harm to the person with disability or others; and*

- *be in proportion to the potential negative consequence or risk of harm; and*
- *be used for the shortest possible time to ensure the safety of the person with disability or others.’*

The person with disability must be given opportunities to participate in community activities and develop new skills that have the potential to reduce or eliminate the need for regulated restrictive practices in the future.

In the authorisation scheme in South Australia, ‘restrictive practices’ relate to practices that are for the primary purpose of influencing a person’s behaviour where it poses a risk of harm to the person or others.

## Chemical restraint

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

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

Chemical restraints are Level 1 restrictive practices that can be approved by the Authorised Program Officer unless there are characteristics that increase the intrusiveness, risks and impact for people with disability.

The following Level 2 chemical restraints must be approved by the Senior Authorising Officer:

- Chemical restraints that are administered through an invasive procedure such as via injections and implants.

- The use of 2 or more psychotropic<sup>1</sup> drugs or more than 5 drugs to manage behaviours. These numbers only reflect medications that are used to manage behaviour and do not include medications that are used to treat a diagnosed mental health condition, a physical illness or a physical condition.
- Hormonal manipulation to manage harmful sexual behaviours and behaviours of concern associated with menstruation (eg. smearing, behaviours demonstrating distress). It does not include hormonal manipulation to treat a medical condition such as endometriosis, a physical condition such as menstrual pain, or where the person with disability has made an informed decision to use contraceptives as a reproductive choice. The Senior Authorising Officer cannot authorise hormonal manipulation for the primary purpose of contraception.

When medications are prescribed for people with disability to manage their behaviour, the prescribing medical practitioner is the clinical decision-maker who determines the purpose of the medication. To support prescribing medical practitioners in their role, registered NDIS providers who implement chemical restraints must ensure that:

- there are appropriate positive behaviour support strategies in place
- the person with disability's medications are reviewed regularly by a qualified professional
- the purpose of medication is clarified and documented
- the use of the medication is consistent with a behaviour support plan

- the person with disability and their decision makers are encouraged to seek a second medical opinion if there are concerns about the use of a medication
- opportunities to safely trial a reduction of chemical restraints are explored with prescribing medical practitioners.

## Environmental restraint

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

*'environmental restraint, which restricts a person's free access to all parts of their environment, including items or activities'*

*The Disability Inclusion (Restrictive Practices - NDIS) Regulations 4 (3) and 5 (3) identify that preventing access by a person with disability to an area that individuals are ordinarily not permitted to enter will be taken not to be an environmental restraint.*

This is to reflect ordinary community standards of privacy and access that may occur in shared housing, workplaces and community spaces such as:

- staff rooms in disability accommodation premises where staff may undertake office work, sleep, store their personal belongings or confidential client files
- the private rooms of other clients in shared accommodation
- the locking of bathroom doors and toilet doors while they are in use
- locked utility and maintenance areas in disability accommodation premises where general access is restricted, including for staff members.

<sup>1</sup>Psychotropic drugs are "any drug capable of affecting the mind, emotions and behaviour". The three main categories are antidepressants, anti-anxiety medications (including benzodiazepines) and anti-psychotics.



The locking of external gates and external doors for security purposes against external parties (including placing limitations on external parties coming into shared disability accommodation premises) is not an environmental restraint, as long as people with disability inside the premises are able to freely exit as required.

The use of CCTV in shared areas in disability accommodation premises is not considered an environment restraint where its primary purpose is for security against external persons, or for employee oversight. Where CCTV is installed for the purpose of monitoring client behaviour, including behaviour while in seclusion, it is an environmental restraint and can be approved by an Authorised Program Officer.

The use of electronic monitoring devices (eg. motion sensors, alarm mats) and non-electronic means of supervision (eg. observation windows, peep holes) are not environmental restraints in their own right. The use of these observation methods may alert registered NDIS providers to behaviours of concern that require support.

Communication devices that are the primary means by which a person communicates (such as augmentative and alternative communication devices (AAC)) can not be restricted unless they are being used in a way that poses a risk of harm to the person or others, and there is a reasonable alternative the person can use to communicate. In these situations, authorisation must be sought from the Senior Authorising Officer. If there is no reasonable alternative that the person can use to communicate, the restrictive practice is unauthorised.

The grouping of similar items that are locked in a space is considered to be one restrictive practice, while different types of items stored

in a range of locations are considered to be multiple restrictive practices. For example:

- a number of food items locked in a fridge is one restrictive practice
- a number of sharp items locked in one cupboard or drawer is one restrictive practice
- locked chemicals in one cupboard, and locked knives in a drawer are considered to be two restrictive practices.

As a guide, registered NDIS providers should consider the extent of items and extent of locations that a person with disability would not be able to access. Restrictions on entire rooms (such as kitchens or bathrooms) should be avoided as most kitchens and bathrooms can be safely managed through limited environmental restrictions.

### **Environment restraint that is not detention**

Section 23C of the *Disability Inclusion Act 2018* defines detention as:

- any direct or indirect curtailment of a person's ability to leave particular premises or a particular part of particular premises
- a requirement that a person be and remain in particular premises
- the refusal or limitation of access to means to leaving particular premises.

However, Regulation 7 prescribes that the locking of external gates and doors of residential premises is not detention where NDIS supports, and services are provided on a 24-hour basis on those premises to a person with disability who does not have supports to safely leave at their discretion. These situations constitute a Level 2 environmental restraint that can be authorised by the Senior Authorising Officer.



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Where a person with disability does have sufficient supports to safely leave the premises at their discretion but are prevented from doing so, this constitutes detention and must be authorised by the South Australian Civil and Administrative Tribunal (SACAT).

The external gates and doors of an NDIS residential premises may be locked for the safety of residents for several reasons, such as behaviours of concern that place themselves and others at risk, or physical or cognitive impairments that affect their ability to safely navigate roads, traffic and environmental hazards. The Act and Regulations do not differentiate between the genesis of the safety concerns for purposes of this restrictive practice.

Where a person with disability requires continuous accompaniment by another person due their behaviours and the accompaniment is designed to provide an external control on the person's behaviour (where they can go, modifying their interactions with others, modifying their behaviour), this is a Level 2 restrictive practice that must be authorised by the Senior Authorising Officer. Continuous accompaniment of a person because they are at risk of falls, seizures or similar reasons are not a regulated restrictive practice.

In emergency situations, where staff withdraw to a contained space (such as a locked staff room) while the person with disability is not able to leave due to locked external gates and doors, this is an environmental restraint that must be authorised by the Senior Authorising Officer. It is not seclusion as defined by Regulation 7 (2) (b) as the practice is not for the purpose of de-escalation or self-regulation. It should be noted that this categorisation is different to that provided by the NDIS Commission. This difference in categorisation does not impact on the

requirements to ensure that the practice is authorised, and its use reported to the NDIS Commission.

## Mechanical restraint

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

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

Authorised Program Officers are able to authorise Level 1 mechanical restraints such as restrictive clothing (eg onesies, overalls, bodysuits, gloves), helmets, and splints unless there are more than five Level 1 practices, or the restraints require the use of force to implement. More than five Level 1 practices or the use of force needs to be authorised by the Senior Authorising Officer.

Mechanical restraints do not include therapeutic devices that support body position, balance, posture, or alignment. They do not include devices that are used to manage involuntary body movements such as tics, tremors, or dystonia.

Care must be taken to evaluate if therapeutic devices are used in ways that are inconsistent with their primary therapeutic purpose.

## Physical restraint

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

*'the use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for*

*the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person’.*

The use of physical force to implement a restrictive practice (such as holding a person still to apply restrictive clothing) is a physical restraint which must be authorised.

Physical restraint is a high-risk activity, both for the person applying the restraint and the person who is restrained. Consideration should be given to seeking medical advice as to whether the person with disability has an underlying medical condition that may be exacerbated by some or all forms of physical restraint. Where this is the case, medical reviews should occur regularly to ensure the use of the physical restraint is safe and appropriate in the circumstances.

Physical restraint is a Level 2 restrictive practice that must be authorised by the Senior Authorising Officer. Given the risks involved, registered NDIS providers who use physical restraints must ensure that staff are appropriately trained in safe physical restraint techniques that reduce the risk of injury. Certain physical restraints are prohibited because they are associated with high risk of injury and death (see Prohibited Restrictive Practices).

## Seclusion

Section 6 (a) of the *NDIS (Restrictive Practices and Behaviour Support) Rules 2018* defines seclusion as the

*‘sole confinement of a person with disability in a room or a physical space at any hour of the day or night where voluntary exit is*

*prevented, or not facilitated, or it is implied that voluntary exit is not permitted’.*

In South Australia, the Regulations prescribe additional conditions on this definition, identifying that:

- the period of seclusion can not exceed two hours
- may only occur in an emergency situation where it is necessary to prevent serious harm to the person or others,
- is for the purpose of de-escalation or self-regulation.

Seclusion is a Level 2 restrictive practice that must be authorised by the Senior Authorising Officer.

There must be no routine or scheduled use of seclusion.

Seclusion is not a withdrawal of support, but an active intervention involving support, co-regulation and de-escalation. Registered NDIS providers must ensure that the environment in which a person with disability is secluded is safe and comfortable.

Consideration should be given to whether the environment provides the appropriate level of sensory input or reduction that is required to help the person regulate. People with disability must not be unsupervised during seclusion.

The Regulations specify that the period of seclusion must not exceed two hours. In practice, the effective use of seclusion as a supported process to co-regulate and de-escalate a person experiencing a behaviour emergency should take much less time than 2 hours.

Like all restrictive practices, patterns in the use of seclusion must be closely monitored. Where seclusion is consistently used for the maximum period of time, or where multiple

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periods of seclusion are used in close succession, this may have the effect of detention for the person with disability.

In these situations, registered NDIS providers must:

- seek an urgent review of the behaviour support plan with a behaviour support practitioner, the person with disability, their family and other professionals. Continued use of seclusion for the maximum period or in close succession is likely to indicate that the person with disability's needs are not being met and additional support is required for their safety and wellbeing.
- Ask the person with disability's legal guardian (or substitute decision-maker appointed under an advanced care directive) to apply to SACAT for a detention order. Orders for detention are reviewed after the first 6 months, and then at intervals of not more than one year. SACAT is not able to make detention orders for children under the Guardianship and Administration Act 1993.

## Unauthorised restrictive practices

The authorisation scheme seeks to ensure that the use of restrictive practices complies with national and state legislative requirements, and in accordance with the person's behaviour support plan. Behaviour emergencies may arise that are not contemplated by the behaviour support plan. A person with disability's needs may also change to require support that is beyond the restrictive practices that have been authorised.

In these situations, staff may be required to use an unauthorised restrictive practice to ensure the safety of the person with disability or another person. Unauthorised

restrictive practices must be reported to the NDIS Commission within the legal timeframes required. Persistent use of unauthorised restrictive practices may indicate that the person with disability's needs are not being met, additional support is required for their safety and wellbeing, and a review of the behaviour plan is warranted. Registered NDIS providers should seek authorisation for unauthorised restrictive practices as soon as practicable.



## Physical force

Section 23M (4) of the *Disability Inclusion Act 2018* states that ‘a person may use reasonable force in the course of using restrictive practices under this Part (however, the use of force is to be a last resort and must be reasonably necessary to enable the use of restrictive practices’. To be reasonable, the use of physical force must be consistent with the principles outlined in s 23G of the *Disability Inclusion Act*:

- It is used as a last resort, after other means such as verbal guidance or visual prompts have been unsuccessful
- Applying the least amount of force in the least restrictive way for the shortest period of time.

The use of physical force to implement a restrictive practice is a separate restrictive practice in its own right (physical restraint). All restrictive practices that require the use of physical force must be authorised by the Senior Authorising Officer due to the heightened risks for the person being restrained and the person implementing the restraint.

The use of force must be proportionate to the potential negative consequence of harm for the person applying the restraint, and the person being restrained. This means that the degree of force required to physically restrain a person who is hurting themselves or others is likely to be higher than the degree of force required to apply a helmet or restrictive clothing.

Where physical force is used to implement a restrictive practice, registered NDIS providers must monitor the person with disability for signs of injury, distress, and harm. Injuries arising from the use of force must be reported to the NDIS Commission.

## Psycho-social pressure

While the use of force is generally considered in terms of physical force, staff should also consider the power that they have as staff members, as professionals and (for some) as a part of the government. For persons who have directly or indirectly experienced institutionalisation or authoritarian regimes, staff members and professionals may have actual and perceived power that increase psycho-social pressure.

Psycho-social pressure may be exerted through coercion, manipulation, the use of threatening tones or expressions, or implying negative consequences. These practices are prohibited and must not be used.

Psycho-social pressure may be a more subtle and hidden form of force and may reflect value-laden judgements about a person with disability’s lifestyle choices. People with disability are entitled to dignity of risk and to make decisions for themselves even where this holds inherent risks. Where the withholding of food, activities, or items are not related to safety reasons but are designed to influence lifestyle, this is an unreasonable use of psycho-social pressure.

Psycho-social pressure may be exerted despite not being intended. A request from a registered NDIS provider may be experienced by the person with disability as a direction and they may believe that they are not able to make an informed choice.

Registered NDIS providers must ensure that people with disability know the circumstances where they can make a choice, and that the exercise of that choice will not have adverse consequences for them.

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## Concealment

The concealment of a restrictive practice is considered to be a higher level of intrusion and requires a higher level of authorisation. For example, where chemical restraints are concealed in food and drinks and the person with disability is not aware of their use, this must be approved by the Senior Authorising Officer. The crushing or mixing of medications in food or drinks solely to prevent choking is not concealment as long as the person with disability is aware of the practice.

**The use of force must be proportionate to the potential negative consequence of harm for the person applying the restraint, and the person being restrained.**

## Children and the use of Restrictive Practices

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The rights of children with disabilities are stated in Article 7 of the *UN Convention on the Rights of Persons with Disabilities* (2006) and overlap with the *United Nations Convention on the Rights of the Child* (1990) in articulating:

- In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration
- Children have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity.

The *Disability Inclusion Act (2018)* sets out a number of principles that must be applied in the administration of the Act for children and young people, including:

- The recognition that children with disability are more vulnerable to the risk of abuse or exploitation
- The developmental needs of children with disability must be taken into account, with particular focus on critical periods in their childhood and adolescence.

These principles recognise that the needs of children and young people are distinct from those of adults and must be considered within their developmental context. The use of restrictive practices for children and young people must be situated within community standards about the reasonable measures that adults should take to keep children and young people safe. Reasonable steps to lock doors to prevent young children from wandering onto the road may become unreasonable as children develop road safety skills and learn to navigate their environments. Learning to take appropriate

risks safely is an important developmental step for young people, and the overuse of restrictive practices may impede this important learning process.

Children (especially those who are in out-of-home care due to abuse, neglect, significant medical needs or disability) are at heightened risk of adverse effects from restrictive practices, particularly physical restraint and seclusion. The use of these restrictive practices may jeopardise children's ability to form safe and trusting relationships with adults and compromise their ability to self-regulate and self-manage. The use of restrictive practices may also contribute to children and young people's feelings of anxiety, fear, helplessness, and hypervigilance.

To recognise the complex circumstances of children and young people in care, and the higher standard of care that should be afforded to this cohort, registered NDIS providers should refer restrictive practices (regardless of level) for children in care to the Senior Authorising Officer where:

- the legal guardian does not consent to the use of restrictive practices
- the young person has sufficient maturity to understand the restrictive practices and why they have been sought, and does not consent to their use.

In some jurisdictions, the use of seclusion is prohibited for children. In the South Australian authorisation scheme, the practice of seclusion is time-limited and involves the active task of de-escalation and regulation. Children and young people who are secluded due to a behaviour emergency must be supported by a caring adult who is supporting the child to de-escalate and regulate.

Children and young people with disability who have experienced physical restraint, seclusion and other restrictive practices must be supported to have discussions and debriefing outside of the incident, wherever possible. These discussions and debriefs must be aimed at helping the children and young person to understand why, when and how a restrictive practice will be used, and support the restoration of relationships with safe and caring adults.

**In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration**



# Authority to Enter, Search, Retain items

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Sections 23N (5) and 23O (6) of the *Disability Inclusion Act 2018* permit registered NDIS providers to:

- enter and remain in premises where a person with disability may be found
- search their clothing and possessions for items that the person with disability may use to harm themselves or others, or to damage property
- take possession and retain items for as long as is necessary for safety reasons.

These provisions are intended to prevent the physical harm that may arise from a person with disability ingesting food that may be a choking hazard, cause anaphylaxis or other serious medical complications. While the dangers are immediate in many situations, some dangers may arise over time if unsafe foods are not limited.

The provisions are also intended to prevent the harm that may arise from a person with disability retaining objects (including knives, scissors, needles) that may be used to hurt themselves or others, or damage property. As this authority is a significant power, its use must be considered in the context of the likelihood and the severity of the harm arising from the person's possession of the object. These provisions cannot be used to:

- undertake routine searches to identify concerning behaviours
- remove an item that a person is not permitted to have (eg. rationed money, cigarettes or junk food) but that does not cause harm to themselves or others
- search for suspected contraband such as illicit drugs or stolen items

Registered NDIS providers must have a suspicion on reasonable grounds that the person may use an object to cause harm to themselves or others or to damage property, and that the search and retention of the item is required for safety.

The Act requires that such a search be carried out expeditiously and in a manner that avoids causing any humiliation or offence. Registered NDIS providers undertaking searches under these provisions can not conduct a search that involves contact with or exposure of intimate parts of the body.

Registered NDIS providers should:

- ask the person with disability whether they have a preferred person to conduct the search where this is possible (eg. staff who have a positive relationship with the person, staff member of a preferred gender)
- ask the person with disability to turn out their pockets and remove any exterior clothing
- use the least amount of force that is required to remove external clothing if the person refuses
- ensure that any use of force is consistent with the behaviour support plan and approved as a physical restraint, or reported as an unauthorised restrictive practice
- arrange for another staff member to be present to ensure that protective practices are maintained where possible.



Where an item can be safely returned to the person (eg. when the situation has been de-escalated and the person is feeling calm and settled), it must be returned. Police advice should be sought about dealing with illegal items that may be found in a search such as illicit drugs or weapons.

Registered NDIS providers must develop internal procedures to inform decisions to undertake a search under these provisions, and the processes that must be adhered to within their organisation. To support consistent approaches by registered NDIS providers, the Senior Authorising Officer will provide an annotated template setting out the requirements.

**The Act requires that such a search be carried out expeditiously and in a manner that avoids causing any humiliation or offence.**

Section 23C of the *Disability Inclusion Act 2018* defines detention as:

- Any direct or indirect curtailment of a person's ability to leave particular premises or a particular part of particular premises
- A requirement that a person be and remain in particular premises
- The refusal or limitation of access to means to leaving particular premises.

The curtailment of the person's liberty can be via a direct means such as locking a door or gate, refusal to provide an access code, or creating a physical barrier (including by blocking exits). It may involve indirect means such as placing conditions on the person's exit (eg. it must be approved by a particular person or is time-limited). Indirect curtailment may also occur when a person is led to believe that they cannot leave or is coerced or pressured not to leave.

Regulation 7 prescribes two limited exceptions to this definition of detention:

- The locking of external gates and doors of residential premises where NDIS supports and services are provided on a 24-hour basis to a person with disability who does not have supports to safely leave at their discretion (see Environment Restraints)
- The temporary confinement (not exceeding 2 hours) of a person with disability in an emergency that is reasonably necessary to prevent serious harm and is for the purpose of de-escalation or self-regulation (see Seclusion).

Detention must be authorised through another legal authority, such as by SACAT under their special powers to place and detain protected persons under the Guardianship and Administration Act 1993. Registered NDIS providers are not able to directly apply to SACAT for detention orders; this must be sought by the person with disability's guardian.

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## Interface between authorisation scheme and guardianship orders

Nothing in the Disability Inclusion Act 2018 derogates from or limits the operation of the Guardianship and Administration Act 1993 or any other law that authorises the use of restrictive practices.

It is possible that a person with disability may require orders for special powers to place and detain under the Guardianship and Administration Act as well as authorisation for restrictive practices under the Disability Inclusion Act. The interface between these two systems should be guided by the following principles:

- The importance of holistic assessment and intervention based on a comprehensive understanding of the person's circumstances and needs
- The reduction of administrative burden for the person, their carers, families and service providers.

Where special power orders are required to place, detain, and apply restrictive practices for a person with disability, a single application should be made by the guardian to SACAT for authorisation of the restrictive practices and detention. The application to SACAT must first seek the appointment of a guardian (if one does not exist) and then the guardian may apply for special powers.

Where a person has existing orders from SACAT to place and/or detain, and new restrictive practices are required, an application can be made to the Authorised Program Officer or Senior Authorising Officer for additional restrictive practices authorisation (including those requiring the use of force).

Where a person has an existing authorisation from SACAT for restrictive practices (but no orders to place or detain), future applications for authorisation of restrictive practices (including those requiring the use of force) can be made to the Authorised Program Officer or Senior Authorising Officer.





The Regulations prescribe the kinds of restraints that are prohibited due to the high risk of injury and death that may arise from their use. These forms of physical restraints must not be used under any circumstances.

The use of punishments to manage behaviour is ineffective, has no place in positive behaviour support and are not restrictive practices. Punishments include:

- the use of aversive practices that cause pain, distress, and noxious or unpleasant experiences
- the removal of pleasant and desirable experiences or activities (including social, recreational, community, physical and sexual activities)
- the withholding of basic needs, including access to food, water, shelter, social and family relationships, culture, and language
- exclusionary behaviour such as ignoring, excluding or rejecting a person with disability in personal and social interactions.

Some practices that are used for a protective purpose may be experienced as a punishment by people with disability, such as the cancellation of a preferred activity. The behaviour support planning process provides an important means to clarify the safety concerns, and the practices that are required to protect the person and others from harm. The use of risk assessments also provides an important means of accountability and transparency:

- to identify that there is a genuine safety issue that requires a protective response
- to explore other strategies that could be used to manage that risk.

**The use of risk assessments also provides an important means of accountability and transparency**

# Authorised Program Officers

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## Nomination of individuals as Authorised Program Officers

Authorised Program Officers play a key role in the authorisation scheme, authorising the use of Level 1 restrictive practices for people with disability and endorsing the use of Level 2 restrictive practices for the Senior Authorising Officer's authorisation. Their adherence to national and state requirements ensures that Level 1 restrictive practices are only authorised where appropriate behaviour assessment, support and interventions have been demonstrated, and the restrictive practice is included in a behaviour support plan.

To ensure that they have the requisite skill, knowledge and experience, Authorised Program Officers must have:

- tertiary qualifications relevant to the functions of an Authorised Program Officer under the Act (such as allied health, nursing, education, or a disability-specific or behaviour-specific discipline); and
- extensive experience and knowledge in the planning, development, implementation, evaluation, and monitoring of behaviour interventions and supports.

Authorised Program Officers should also be familiar with trauma-informed practices, client-centred approaches and the impact of colonisation and systemic racism for Aboriginal people. Authorised Program Officers who authorise restrictive practices for children and young people must have a sound understanding of child development and developmental trauma. Authorised Program Officers should have strong professional networks and be able to seek cultural, religious, gender and issue-based expertise to guide their authorisation decisions.

Authorised Program Officers must recuse themselves from authorising restrictive practices where they have been directly involved in the behaviour support planning process for the person. In these situations, the matter may be referred to a different Authorised Program Officer for the registered NDIS provider, or to the Senior Authorising Officer.

Registered NDIS providers may nominate a sufficient number of persons to be Authorised Program Officers to ensure that they are able to meet their authorisation requirements based on participant numbers, staff leave and movements, and recusals.

In limited circumstances, very small or newly established registered NDIS providers may negotiate to refer their matters directly to the Senior Authorising Officer if they are unable to sustain an Authorised Program Officer role within their organisation. Approval of this arrangement is at the discretion of the Senior Authorising Officer.

## Quality Assurance and Service Improvement

Authorised Program Officers will have access to data reports about their organisation's authorisations and use of restrictive practices. This organisation-specific data will complement the annual reporting that will be provided to Parliament about the number and types of restrictive practices authorised by the Senior Authorising Officer each year. The data is designed to support registered NDIS providers to analyse the trends and patterns of restrictive practices in their organisation and target:

- preventative and alternative supports for people with disability
- staff professional development and training
- policy and program review and development.



## Input into Authorisation Decisions

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Registered NDIS providers should ensure that Authorised Program Officers can contribute to organisational planning and development, either directly or indirectly through the provision of reports and information.

Registered NDIS providers should also ensure that Authorised Program Officers are able to maintain their professional knowledge, skills and understanding about national and state restrictive practices requirements through participation in staff training, networking, and communities of practice.

**Authorised Program Officers should have strong professional networks and be able to seek cultural, religious, gender and issue-based expertise to guide their authorisation decisions.**

People with disability are entitled to contribute to decisions about their care to the greatest extent possible at every stage of decision making. This includes being able to provide input into decisions about the authorisation of restrictive practices, and having their views considered by the Authorised Program Officer and/or the Senior Authorising Officer.

People with disability and their family members should be asked if there is any information they would like the Authorised Program Officer or the Senior Authorising Officer to know in making the authorisation decision, and have their views conveyed to the authoriser in the most direct form possible. A person with disability may wish to speak to the Senior Authorising Officer and the DHS Restrictive Practices Authorisation Team about Level 2 restrictive practices in their circumstances. This information should be conveyed in the application for authorisation.

# Appeal and Complaints

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The ability to appeal a reviewable decision or make a complaint about a service are important quality assurance mechanisms that protect the rights of people with disability and contribute to service improvement.

The provision of information about appeals and complaints should be a standard part of communication about restrictive practices decisions and should be provided in accessible ways. The effective use of appeals is an important means of demonstrating the integrity and rigour of the authorisation scheme.

People with disability (particularly children and young people), their families, carers and guardians should be encouraged to seek a review or make a complaint if they are concerned about a decision, interaction, or service they have received. They may be concerned about a procedural error (the correct process was not followed), a factual error (the correct information was not provided), or that the outcome was unfair or unreasonable in their circumstances.

People with disability may need additional support to:

- clarify their concern
- identify the outcome they are seeking
- be reassured that they will not get into trouble or have their supports jeopardised by making a complaint or making an appeal
- seek assistance from an advocacy service.

The following are reviewable decisions under the Disability Inclusion Act 2018 for the restrictive practices authorisation scheme:

- S 23L - A decision by the Senior Authorising Officer about the authorisation of a nominated person to be an Authorised Program Officer, including any conditions or limitations on that authorisation

- S 23N - a decision of an Authorised Program Officer about the authorisation of Level 1 restrictive practices
- S 23O - a decision of the Senior Authorising Officer about the authorisation of Level 1 and 2 restrictive practices
- S 23P - a decision of the Senior Authorising Officer about the revocation of authorisation to use restrictive practices
- S 23Y - a decision of the Senior Authorising Officer in the review of a decision by the Authorised Program Officer or NDIS service provider

A person who is aggrieved by a decision of an Authorised Program Officer or a registered NDIS provider is entitled to a review by the Senior Authorising Officer, in accordance with s 23Y of the Disability Inclusion Act. An application for review must be made within 30 days after the day on which the decision was made. The Senior Authorising Officer may extend this period for an appropriate reason. The Senior Authorising Officer may confirm, vary, or reverse the decision under review.

The South Australian Civil and Administrative Tribunal (SACAT) may review the decisions of the Senior Authorising Officer. An application for review must be made within 30 days of the decision (unless SACAT allows an extension of time due to special circumstances) by:

- the person to whom the decision relates
- the person's family members, guardian or nominated advocate
- a prescribed NDIS provider who delivers NDIS supports to the person.



An authorised restrictive practice may be implemented while an appeal is pending if the practice is required to maintain the safety of the person with disability and others around them, or where there is a serious risk of harm.

The right to appeal a reviewable decision is different from the right to make a complaint.

A complaint is an expression of dissatisfaction about services or staff where a response is explicitly or implicitly required. Complaints may relate to interpersonal interactions with staff, unreasonable delays, or concerns about communications.

- Complaints about Authorised Program Officers and NDIS service providers must be made to the registered NDIS provider through their internal complaint management process. Complaints about registered NDIS providers can also be made to the NDIS Commission.
- Complaints about the Restrictive Practices Authorisation Team must be provided to the Senior Authorising Officer. Complaints about the Senior Authorising Officer must be provided to the Executive Director responsible for the restrictive practices authorisation scheme in the Department of Human Services.

The review of complaints and appeals can provide an important source of information about opportunities to improve service delivery and supports for people with disability.





# References and Key Documents

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## Legislation

National Disability Insurance Scheme Act 2013 (Cth)

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

National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018 (Cth)

Disability Inclusion Act 2018 (SA)

Disability Inclusion (Restrictive Practices-NDIS) Regulations 2021 (SA)

Guardianship and Administration Act 1993 (SA)

## Documents

NDIS Quality and Safeguarding Framework (2016). Australian Government.

NDIS Quality and Safeguards Commission (2021). Regulated restrictive practices with children and young people with disability: Practice guide. Penrith, Australia: NDIS Quality and Safeguards Commission.

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

NDIS Quality and Safeguards Commission (2019). Positive behaviour support capability framework: For NDIS providers and behaviour support practitioners. Penrith, Australia: NDIS Quality and Safeguards Commission.

People with Disability and Supported Decision-Making and the NDIS. National Disability Services

National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector (2013). Australian Government.

National Principles for the Authorisation of Restrictive Practices. Australian Government.

National Zero Tolerance Framework



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**When communities are inclusive and fair, people with disability can participate and contribute on the same basis as all others.**





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