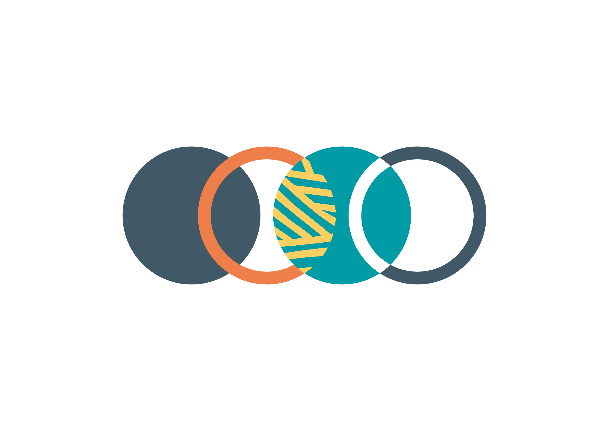
Restrictive Practices Manual

for Authorised Program Officers



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# Purpose

The Authorised Program Officer (APO) plays a key role in the Restrictive Practices Authorisation Scheme (RPAS), 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 (SAO) authorisation. 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 and consistent with a behaviour support plan (BSP).

This document provides APOs guidance about their role, responsibilities, and functions. It outlines their legislative obligations under the *Disability Inclusion Act 2018* (as amended by the *Disability Inclusion (Restrictive Practices – NDIS) Act 2021* (the Act), *Disability Inclusion (Restrictive Practices – NDIS) Regulations 2021* (the Regulations) and the Restrictive Practice Guidelines (the Guidelines).

# Scope

This document applies to all APOs who have been authorised by the SAO to make restrictive practices authorisation decisions for NDIS participants receiving NDIS supports from NDIS service providers.

# Authority

The [*Disability Inclusion Act 2018*](https://www.legislation.sa.gov.au/lz?path=/c/a/disability%20inclusion%20act%202018) (the Act, as amended by the [*Disability Inclusion (Restrictive Practices - NDIS) Amendment Act 2021*](https://www.legislation.sa.gov.au/lz?path=/v/a/2021/disability%20inclusion%20(restrictive%20practices%20-%20ndis)%20amendment%20act%202021_18)) establishes the legislative framework for the authorisation of restrictive practices by registered NDIS providers for NDIS participants in South Australia.

Section 23L of the Act provides the authority for the SAO to authorise a person who holds appropriate qualifications and has the experience prescribed by the regulations to be an APO for a specific NDIS provider.

APOs are given authority to authorise the use of level 1 restrictive practices under section 23N of the Act. APOs must comply with the Act, the [Regulations](https://www.legislation.sa.gov.au/__legislation/lz/c/r/disability%20inclusion%20(restrictive%20practices%20-%20ndis)%20regulations%202021/current/2021.124.auth.pdf) and the [Guidelines](https://www.sa.gov.au/topics/care-and-support/disability/restrictive-practices/resources/restrictive-practices-guidelines) when undertaking their functions.

# Procedures

## 4.1 APO Status

Section 11 of the Regulations sets out the minimum qualifications and experience required by APOs:

* tertiary qualifications relevant to the functions of an APO 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.

Examples of tertiary qualification include but are not limited to:

* a degree in social work, occupational therapy, speech pathology, physiotherapy, or developmental education
* a degree or diploma in nursing
* a degree in education or early childhood education
* a diploma in education support
* a Certificate III or IV in Community Services or Disability.

Where a person is working towards a substantive qualification such as a degree and has demonstrated equivalency with another qualification that makes them eligible to be an APO, this may be authorised by the SAO.  This will be assessed on a case-by-case basis.

Examples of demonstrated experience and knowledge in behaviour support interventions and supports may include but are not limited to:

* training and professional development in behaviour support
* work history of behavioural assessments, making environmental, social, interpersonal adjustments to prevent or respond to behaviours of concerns, and developing strategies to teach new skills and behaviours
* registration with the NDIS Commission as a Behaviour Support Practitioner.

An APO must have the necessary skills to assess a behaviour support plan against the legal and practice thresholds set out in the Act, Regulations and Guidelines, as well as identify gaps and inconsistencies within the behaviour support plan. Whilst some individuals may have extensive experience within the sector, this may not meet the required practice experience and knowledge in behaviour support interventions and supports.

APOs are authorised with respect to a specific NDIS implementing provider. An individual’s status as an APO is not transferable between employment with different providers. Should an individual move between providers, they will need to seek authorisation to be an APO with respect to that implementing provider organisation.

It is expected that APOs will be supported by their organisation to access professional development opportunities run by the Restrictive Practices Unit (RPU), including:

* foundational APO training of approximately 4 hours
* communities of practice
* ad hoc training and development opportunities as required.

Implementing providers who nominate an APO have the ability to withdraw an APO nomination or seek for an APO to be made inactive on the Restrictive Practices System (RPS). This request must be made by an account owner within the organisation, using the RPS. This may occur when:

* an APO changes roles within an organisation
* organisational capacity changes
* another employee is identified to become an APO
* the APO leaves the organisation.

The Senior Authorising Officer can revoke an individual’s authorisation to be an APO under Section 23L (4) of the Act. These decisions are made at the discretion of the SAO, and may occur for the following reasons:

* serious misconduct, including but not limited to, the deliberate misrepresentation of information to the SAO, or omission of information to the SAO
* serious maladministration including but not limited to, breaches of the legislation, or conduct that is unjust, oppressive or discriminatory
* ongoing concerns regarding an APO’s decision making where other methods of remedy have been unsuccessful.

Where authorisation as an APO is revoked by the SAO, this revocation will be provided in writing and published in the Government Gazette. Revocation of APO status is a reviewable decision to SACAT, upon appeal by the APO.

## Conflicts of Interest

The Restrictive Practices Guidelines state that APOs must “recuse themselves from authorising restrictive practices where they have been directly involved in the behaviour support planning process for the person.” This ensures that the authorisation decision is an unbiased assessment of the person’s behaviour support interventions and the restrictive practices required to prevent or minimise the risk of harm arising from the person’s behaviours.

This means that APOs cannot endorse or authorise restrictive practices where they:

* contributed to the development of the BSP for that participant, including suggesting specific interventions, or restrictive practices
* previously developed a BSP for the participant in the past three years
* are involved in the day-to-day support or case work for the participant
* have consulted on the case or were involved in decision making regarding the participant (APOs can provide general support, supervision, or advice to staff)
* have a personal relationship with the participant (family member, friend etc).

APOs should consider whether others may perceive there to be a conflict of interest. They should recuse themselves from authorising or endorsing restrictive practices where there is a perceived conflict of interest.

If there is a conflict of interest, APOs should refer the matter to another APO within their organisations or directly to the SAO. Where a conflict of interest has been identified, the APO should not review, endorse, or authorise the matter.

Where an APO has endorsed or authorised a restrictive practice and a conflict of interest becomes known, the APO should take steps to address the conflict of interest including consultation with other professionals and the SAO. APOs should be able to provide evidence of the steps taken if required.

The NDIS Practice Standards require implementing providers to have a conflict-of-interest policy. APOs should refer to their organisations policy to identify any other actions that may be required with regards to potential or actual conflicts of interest.

## Engaging with participants and their families

APOs may need to engage with participants and/or their families/guardians to confirm or clarify information or evidence for the purpose of authorisation or endorsement. This may include:

* evidence of consultation and participant involvement
* to engage in discussions regarding their contribution to the decision-making process in the development of the plan
* dispute resolution and review processes
* to seek further information about the participant, the restrictive practice(s), and their views about the practice(s).

This section provides APOs with some specific considerations when needing to engage with participants to review implementing providers’ consultation with NDIS participants. It is not exhaustive.

APOs should consider additional resources when engaging with participants from diverse backgrounds. This may include seeking information from within their organisation such as case workers or support workers who are very familiar with the participant. It may involve seeking information from the participant’s family or a member of the participant’s community, such as a cultural leader. To ensure an intersectional perspective, APOs are encouraged to seek advice from a range of sources to help them understand the participant’s perspective.

### Children and Young People

Children and young people have a right to express their views on things that affect them, particularly things that impact on their human rights. It is important that APOs confirm that children and young people’s views have been considered and documented in line with their developmental age and maturity.

The views of all children, including young children and children with developmental delays, can be effectively included in the development and implementation of behaviour supports.

Where the nature of the child or young person’s disability limits effective communication, APOs should consider how the voice of the child or young person was considered. This may include:

* observations of the child or young person
* information regarding changes in behaviours or responses.
* information from the child or young person’s parents or guardian
* case notes and case plans where the child or young person’s support workers were involved.

It is strongly encouraged that APOs do not use the opinions of the parent or guardian as the ***sole*** source of information when seeking the voice of a child or young person.

### Aboriginal Peoples

The term ‘Aboriginal’ has been used throughout this document to reference all Aboriginal and Torres Strait Islander peoples. DHS acknowledges and respects this preference of the South Australian Aboriginal community in written and spoken language.

Authorisation decisions must be made within the context of culturally safe practice and informed by consultation with the person with disability, their families, carers, kin, and people with cultural knowledge and expertise.

APOs should ensure that Aboriginal peoples have been engaged in the behaviour support planning process in a way that is culturally safe, trauma-informed, and strength-based.

APOs should review documentation for evidence of cultural considerations in behaviour support planning. This may include:

* information about the participant’s family (including extended family and kin) and community
* details of how the participant is supported to maintain their cultural identity, language, and connection to country and family which could lead to improved social and emotional wellbeing
* How the use and implementing of the restrictive practice reflects an understanding of the experiences of Aboriginal peoples in terms of systemic racism, dispossession from land, trauma, and statutory interventions.

APOs are encouraged to seek appropriate support and advice from family and community members, Elders and Aboriginal Community Controlled Service Sector employees, when reviewing cultural considerations documented within behaviour support plans.

### Culturally and Linguistically Diverse Communities

It is important when determining restrictive practices for participants from culturally and linguistically diverse (CALD) communities that considerations are made within the context of culturally safe practices and in consultation with the person with disability, family/kin, and people with cultural authority.

When reviewing and authorising restrictive practices, APOs should keep in mind that people from CALD backgrounds may:

* have differing views of disability and restrictive practices within a cultural context
* have language barriers that can result in different levels of understanding about behaviour support and restrictive practices
* may be triggered by reminders of past experiences when discussing restrictive practices
* require the inclusion (or exclusion) of extended family/community as part of cultural requirements or expectations
* may prefer to speak to a person of a different gender.

### Alternative Communication

Where the nature of the person’s disability presents communication barriers to effectively participating in the behaviour support planning or authorisation process, it is important that an alternative means to effectively include them is tried. This may include:

* use of augmentative communication systems
* non-verbal forms of communication including hand gestures, eye contact, sounds and movements
* accessing an advocate or a person who is familiar with the participant and can interact effectively
* use of social stories and easy read resources
* engaging with an interpreter.

APOs should ensure that the individual’s communication support person does not have a conflict of interest regarding the restrictive practice/behaviour support plan.

## Authorisation Requests

### 4.4.1 Receiving Restrictive Practice Requests

APOs will receive restrictive practice requests through the RPS.

The restrictive practices system (RPS) is a web-based system that can be accessed at the link below:

<https://www.rps.sa.gov.au/login>

Comprehensive guides and videos on the functions of the RPS are located on the Restrictive Practices [website](https://www.sa.gov.au/topics/care-and-support/disability/restrictive-practices/feedback,-complaints-and-appeals) and have been linked below:

* [Provider Registration](https://www.sa.gov.au/__data/assets/word_doc/0012/778719/Guide-Provider-Registration.docx)
* [Nominating Authorised Program Officers](https://www.sa.gov.au/__data/assets/word_doc/0011/778718/Guide-Nominating-Authorised-Program-Officers.docx)
* [Finding, Adding and Editing a Participant](https://www.sa.gov.au/__data/assets/pdf_file/0004/783184/RPS-Guide-finding-adding-editing-a-participant.pdf)
* [Add and Edit a Behaviour Support Plan Summary](https://www.sa.gov.au/__data/assets/pdf_file/0009/783180/RPS-Guide-add-edit-behaviour-support-plan.pdf)
* [Add, Edit and Submit a Restrictive Practice Request for Authorisation](https://www.sa.gov.au/__data/assets/pdf_file/0005/783176/RPS-Guide-add-edit-and-submit-RP-requests.pdf)
* [Record an Authorisation Decision](https://www.sa.gov.au/__data/assets/pdf_file/0007/783178/RPS-Guide-record-an-authorisation-decision.pdf)
* [Generate an Authorisation Statement](https://www.sa.gov.au/__data/assets/pdf_file/0011/790895/Restrictive-practices-system-guide-generate-an-authorisation-statement.pdf)
* [Report Restrictive Practice Usage](https://www.sa.gov.au/__data/assets/pdf_file/0009/791028/Restrictive-practices-system-guide-report-restrictive-practice-usage.pdf)

All authorisation decisions must be documented within the RPS, as this ensures that APOs meet their obligation under Section 12(2)(b) of the Regulations.

All documentation used by an APO to make their authorisation decision must be uploaded onto the RPS under the plan documents tab of the participant’s behaviour support plan summary. This includes supplementary documents such as allied health assessments, medical reports or photos of the restrictive device or space.

### 4.4.2 Application Criteria

APOs can only authorise restrictive practices where they have been identified by the behaviour support practitioner as an implementing provider for the restrictive practice. APOs must confirm that they are identified either within the BSP or on the NDIS Commission’s portal as an implementing provider for that restrictive practice.

APOs must confirm that applications for restrictive practices meet the criteria established by section 23N of the Act:

* + the NDIS participant is displaying behaviour that constitutes a risk of harm; and
  + the use of level 1 restrictive practices is necessary to minimise the risk of harm, or to prevent further harm from being caused.
  + the NDIS participant has an NDIS Behaviour Support Plan. The BSP must be written by a behaviour support practitioner who is employed by an NDIS registered provider and deemed suitable by the NDIS Quality and Safeguarding Commission.
  + the BSP was prepared in consultation with the NDIS participant.
  + the use of level 1 restrictive practices of the relevant kind is contemplated by, and consistent with, the NDIS participant's BSP.

The APO is required to review each restrictive practice sought using these criteria. Any request that does not meet these requirements must not be endorsed or authorised by the APO.

APOs must then identify whether it is a Level 1 or Level 2 restrictive practice. This will determine whether the APO has the authority to authorise the restrictive practice (Level 1), or whether they must refer the application to the SAO.

The following restrictive practices must be referred to the SAO, even where the individual restrictive practice is a level 1 restrictive practice:

* more than five Level 1 restrictive practices in relation to a participant. Where the same restrictive practice is used to respond to the same identified behaviour across multiple settings (for example locking up knives in the home and at respite) this is considered a single restrictive practice.
* where there is a combination of level 1 and 2 restrictive practices being requested
* two or more psychotropic drugs have been prescribed for the purpose of managing a person’s behaviour
* more than five drugs are prescribed for the purposes of managing a person’s behaviour
* the use of physical force is required to implement the restrictive practice.

Detailed information regarding Level 1 and Level 2 restrictive practices can be found in the [Restrictive Practices Schedule](https://www.sa.gov.au/__data/assets/word_doc/0007/783358/Restrictive-practices-schedule-April-2023-v2.docx). APOs are encouraged to use the Restrictive Practices Schedule to determine the authorisation pathways for all restrictive practice requests.

### 4.4.3 Consultation

While section 23M of the Act permits the use of restrictive practices without the consent of the person with disability, informed consent remains a core practice principle within the Guidelines.

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 considered and given practical effect wherever possible.

The role of the APO is to ensure there is evidence that the BSP has been developed in consultation with the NDIS participant and their guardian (where relevant). The APO can only endorse or authorise a restrictive practice only where there is evidence that the BSP has been developed in consultation with the NDIS participant.

Examples of how the APO can identify that the BSP was developed in consultation with the NDIS participant:

* the implementing provider gives minutes from meetings held with the NDIS participant about the BSP
  + the BSP includes details of meetings held with the NDIS participant about the BSP and the restrictive practices
  + the implementing provider provides consultation documentation, using the Restrictive Practice Unit’s [Consultation template](https://www.sa.gov.au/__data/assets/pdf_file/0008/841184/Participant-consultation-template-and-example.pdf)
  + the BSP or support documents sets out the observations of the NDIS participant’s behaviours, facial expressions, gestures in response to their behaviour supports and restrictive practices
  + the NDIS participant was unable to participate directly in the BSP due to their cognitive and communicative capacity, however their views were documented by the behaviour support practitioner or the implementing provider through discussions held with the NDIS participant’s guardian and/or family
  + the APO spoke directly with the NDIS participant about how they were consulted on the BSP and the restrictive practices.

An APO should consider if the NDIS participant has been provided with an opportunity to express their own thoughts and feelings regarding the restrictive practice. Does the participant know:

* + why the implementing provider believes restrictive practices are needed
  + when the restrictive practices would be used
  + the risks and benefits of their use
  + how the provider will monitor the risks when using a restrictive practice
  + alternative supports that will be used prior to using a restrictive practice
  + how they will work with the NDIS participant to reduce or stop using them
  + they can consent to the restrictive practice or refuse to give consent
  + they have a right to withdraw consent
  + they are informed about authorisation processes
  + they are told about how to appeal decisions or make a complaint.

The APO should not consider the signing of a consent form or the BSP as consultation, without other evidence.

#### Consultation with children and young people

APOs must consider whether a child or young person has been given reasonable opportunity to collaborate on the development of their BSP, in line with their developmental skills.

The Guidelines require APOs to refer all restrictive practices to the SAO where a young person in care has sufficient maturity to understand the restrictive practices and does not agree with the restrictive practice.

### 4.4.4 Complex Matters

APOs can seek guidance and support from the Restrictive Practices Unit (RPU) for the authorisation of any Level 1 restrictive practice or the endorsement of any Level 2 restrictive practice.

The RPU will provide an APO with guidance on matters, including helping the APO to assess whether legal and practice thresholds are met, however the APO has the authority to make the authorisation decision on a Level 1 restrictive practice.

An APO may also refer a complex authorisation decision directly to the SAO for authorisation.

Some complex matters require specific considerations and must be referred to the SAO even where the restrictive practice is a Level 1. This is due to the high likelihood that the decision may be appealed:

* children and young people under the guardianship of the Chief Executive (Department for Child Protection) where the legal guardian does not consent to the restrictive practice.
* children and young people under the guardianship of the Chief Executive (Department for Child Protection) where the young person is competent to make decisions about restrictive practices and does not consent to the practice.
* adults under the guardianship of the Public Advocate, where the guardian does not consent to the restrictive practice.
* where the legal guardians of the NDIS participant are in dispute about consent to the restrictive practice.

Detailed guidance on which complex matters require referral to the SAO can be found within the [Restrictive Practices Schedule](https://www.sa.gov.au/__data/assets/word_doc/0007/783358/Restrictive-practices-schedule-April-2023-v2.docx).

APOs are still required to consider the restrictive practice and make an endorsement decision before forwarding the request to the SAO.

### 4.4.5 Behaviour Support Plans

BSPs play a key role in supporting people with behaviours of concern. The quality of a BSP has a direct impact on reducing and eliminating restrictive practices.

The Act defines a BSP as one that meets the *National Disability Support Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (NDIS Rules). This requires APOs to consider the NDIS Rules when making an endorsement or authorisation decision.

APOs do not approve the BSP. The role of the APO is to review the BSP in the context of the legal and practice thresholds for authorising a restrictive practice. The Statement of Reasons guides the APO through the process to ensure the relevant parts of the plan are considered.

#### **Behaviour of concern that causes a risk of harm**

Legal Requirement:

Section 23(N)(1) of the Act details that a restrictive practice can only be authorised where a person is displaying a behaviour of concern that constitutes a risk of harm. The Act and Regulations define risk of harm (in relation to the use of restrictive practices and behaviour) as:

*(a) the use of force against another person, or an express or implied threat that force will be used against another person.*

*(b) self-harm, or an express or implied threat of self-harm.*

*(c) behaviour that substantially increases the likelihood that physical or mental harm will be caused to the person or to any other person (whether intentionally or unintentionally);*

*(d) any other behaviour of a kind prescribed by the regulations.*

The Regulations further prescribe that a risk of harm is also:

*(a) causing damage to property, or an express or implied threat that damage will be caused to property (whether the property belongs to the person or any other person);*

*(b) causing human biological material to come into contact with a person or object (whether by directly applying the material to the person or object or otherwise).*

The role of the APO is to confirm that there is a behaviour of concern that creates a risk of harm and has been documented within the BSP, risk assessment or any other supporting documentation.

Restrictive practices should not be used to manage all risks, only the risk of harm from behaviours of concern that cannot be managed in a less restrictive way. Where the person is engaging in an activity that any other person may engage in (such as drinking alcohol, smoking cigarettes) it must be established that the risk is beyond the risks that any member of the community engaging in that activity is likely to experience.

Practice Considerations:

It is best practice for a risk assessment to be undertaken for all identified behaviours that present a risk of harm. The risk assessment may include:

* assessment of the frequency, severity and duration of the behaviours
* identifying the risks arising from behaviours of concern and the likelihood of these risks occurring
* identifying the risks that may arise due to the use of the restrictive practice(s)
* ensuring the restrictive practice and other strategies are proportionate to the risk of the behaviour of concern.

#### **RP is required to minimise or prevent further harm**

Legal Requirement:

Restrictive practices can only be authorised where it is required to minimise and prevent harm. Under section 23(g) of the Act, the Principles emphasise that restrictive practices should only be used by the implementing provider in limited circumstances, as a last resort, in the least restrictive way and for the shortest period possible in the circumstances. This means there should be evidence in the BSP which demonstrates that other options have been considered/trialled and have been found to be insufficient to address the risk of harm.

The restrictive practice must also not create new harms that are greater or equal to the harms being prevented or minimised and must not displace risk from one setting to another setting. Risk assessments can provide APOs with details of the risks associated with the use of the restrictive practice and how these are being mitigated or reduced.

Practice Considerations:

Where restrictive practices are required, the BSP should include strategies:

* to identify when a behaviour of concern may occur for the NDIS participant
* to prevent behaviours of concern occurring,
* to minimise, reduce or redirect the behaviour

The stages of a behaviour cycle should be clearly identified so that support workers are equipped with preventative strategies and are able to respond to early signs of behaviour escalation before the risk of harm requires the use of restrictive practice.

It is recommended that restrictive practices which do pose potential harms arising from its use (for example seclusion and physical restraint) have a protocol developed to support the safe implementation of the restrictive practice by staff.

#### **Restrictive Practice is consistent with the BSP**

Legal Requirement:

APOs cannot authorise a restrictive practice that has not been clearly recorded within the BSP. The requested restrictive practice must be consistent with the BSP (for example, if the BSP identifies that the restrictive practice required is restricted knives, the restrictive practice request cannot be for a locked kitchen.

Practice Considerations:

It is recommended that the BSP identify the settings in which the restrictive practice will be used, and any specific considerations related to the setting when using the restrictive practice.

#### **Skill Development**

Practice Consideration:

The Guidelines detail that skill development is a key component of behaviour support “*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.*” Evidence suggests that developing new skills reduces the likelihood of behaviours of concern and therefore the use of restrictive practices.

Skill development should be linked to the functionally equivalent replacement behaviours and the behavioural indicators that would prompt a reduction in the restrictive practice.

Skill development is only possible where a person has opportunities to take some risks and is only possible where practices are not overly restrictive. Care must be taken to provide children and young people with developmentally appropriate risk-taking opportunities that support skill development.

#### **Monitoring and Review**

Practice Consideration:

The Guidelines detail that 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.”*

It is recommended that there is a documented process for monitoring and reviewing the use of restrictive practices within the BSP that helps to inform a reduction and elimination of the restrictive practice.

#### **Reduction and Elimination**

Practice Consideration:

The South Australian government has endorsed the *National Framework for Reducing and Eliminating the use of Restrictive Practices in the Disability Service Sector (2013)*. The Act, Regulations and Guidelines have been developed with this aim in mind.

Reduction and elimination is often documented within behaviour support plans as the ‘fade out plan’. This language focuses on the elimination of the restrictive practice. However, considerations must be given to reducing the restrictive practice as well as the elimination of the practice.

Reduction and elimination plans should detail the behavioural indicators that would prompt a move to the next step in the fade out plan or a reduction in the restrictive practice. These indicators may include changes to:

* the behaviours of concern (reduced frequency, severity, or duration)
* contexts where the behaviours occur (e.g., behaviours may occur at day options, but not at home)
* the times in the days when the behaviours occur (where the person has consistent times in the day when they are settled and calm)
* increase in skill development or the use of functionally equivalent replacement behaviours
* increase in positive engagements with people or activities that may be used as a basis for further intervention.

The reduction and elimination plan should detail the person responsible for the actions in the plan and the timeframe within which the action should be undertaken.

#### **Professional Development and Staff Training**

Practice Considerations:

Staff training or professional development may be required by the participant’s support workers for the restrictive practices to be safely implemented. This does not always present as formal training sessions. Evidence may be provided in alternative ways such as practitioner modelling onsite and active participation with support staff and participants to implement the plan in the community setting.

Where staff training is recommended by someone other than the behaviour support practitioner, the plan should include who is responsible for actioning the recommendation and the timeframe for this to be undertaken.

## Considerations for Specific Restrictive Practice Types

### 4.5.1 Chemical Restraint

Chemical restraint is the use of medication or chemical substances 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 health disorder, a physical illness, or a physical condition.

NDIS participants may have a range of medications prescribed for different reasons. APOs should review the BSP and supporting documents to clarify:

* the primary purpose of the medications that have been prescribed or used
* whether the drug is a [psychotropic medication](https://www.agedcarequality.gov.au/sites/default/files/media/acqsc_psychotropic_medications_v11.pdf)
* whether restrictive practices authorisation is being sought for all medications that meet the definition of a chemical restraint.

Where a medication has been prescribed for the treatment of a medical or psychological condition, it is best practice to identify who provided the diagnosis and when the diagnosis occurred.

Where there is uncertainty about the diagnosis and the medication could be used to influence behaviours of concern that cause a risk of harm, the medication can be considered a restrictive practice until clarification is sought from the appropriate medical professional. APOs can seek clarification about medications by asking the following questions:

* what medical or mental health condition has the medication been prescribed for?
* How does the medication work in treating the medical or mental health condition?

Where the medication works by managing behavioural symptoms that cause a risk of harm, the medication may be a chemical restraint that requires authorisation. Behaviour support practitioners and implementing providers have obligations to identify any medication that, in their professional opinion, meets the definition of a chemical restraint.

**Hormonal Chemical Restraints**

The use of hormonal chemical restraints differs between men and women. In women, these medications may be used to treat a range of gynaecological issues, contraception, or for menstrual suppression (to stop her period), either for a therapeutic purpose or for behaviour management.

Where hormonal medications are identified for a woman, APOs should consider whether this is being used as a hormonal chemical restraint.

Changes in behaviour may be attributed to the menstrual cycle, even where this hypothesis has not been tested. Links between behaviour and the menstrual cycle should be demonstrated within the behaviour support plan or the Functional Behaviour Analysis.

Where gynaecological conditions have been identified as the reason for the hormonal medication, this should involve a formal diagnosis by an appropriate health professional.

In men, hormonal medications may be given as a means of reducing sexual arousal (anti-libidinal). Where anti-libidinal medications are used to manage high-risk sexual offending behaviours, this should only be on advice by a specialist forensic psychiatrist and after detailed expert assessment. APOs should ensure that monitoring and review of the medication is documented within the BSP at the recommended frequency of every six months, or more often where side effects have been reported.

The Victorian Senior Practitioner’s Office provides detailed advice on [the use of anti- libidinal medication use in people with intellectual disability who sexually offend](https://www.dhhs.vic.gov.au/sites/default/files/documents/201912/Anti-libidinal%20medication%20use%20in%20people%20with%20intellectual%20disability%20271119.pdf).

### 4.5.2 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 purposes 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 would be considered exercising care towards a person.

Physical restraint can pose significant risks to the person and others.

The role of the APO is to confirm:

* the physical restraint being requested is not a prohibited physical restraint
* that force is not being used to implement other restrictive practices without authorisation for the physical restraint.
* The BSP and supporting documentation provides sufficient detail to enable safe, and consistent implementation of the physical restraints.

The APO must review and provide (or not) endorsement prior to forwarding to the SAO.

### 4.5.3 Mechanical Restraint

A 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 but does not include the use of devices for therapeutic or non-behavioural purposes.

It is recommended that specialist advice (such as from occupational therapists or physiotherapists) is sought during the development of the BSP, where mechanical devices are prescribed to ensure:

* the correct mechanical device is used
* the item is correctly fitted
* training and support are provided to workers in the use of the device
* clear instruction is provided around timeframes for use
* homemade devices or devices that have been modified from the original manufacturer’s state are safe and effective for use by the participant.

It is best practice for a behaviour support plan to include a protocol for the use of the mechanical restraint that has been developed in collaboration with the allied health professional.

Where a mechanical device is homemade, APOs must upload photographs of the device to the RPS.

Where there is no evidence of a recent review by an appropriate allied health professional of certain mechanical devices within the past two years (or 12 months for a child or young person), these matters should be referred to the SAO for authorisation. See the [RP Schedule](https://www.sa.gov.au/__data/assets/word_doc/0007/783358/Restrictive-practices-schedule-April-2023-v2.docx) for further information.

### 4.5.4 Seclusion

Seclusion is 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.

Where seclusion is required, APOs should look for evidence in the BSP that:

* there has been consideration of health conditions and risk factors that put a person elevated risk if they are secluded (e.g., choking risks, heart conditions, seizures etc).
* a risk assessment has been done of the physical environment used for seclusion.
* there are plans for active intervention involving support, co-regulation, and de-escalation during the period of seclusion
* supervision arrangements are clear and documented.

**For a restrictive practice to be considered seclusion:**

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

There must be no routine or scheduled use of seclusion. Patterns of seclusion use should be examined to ensure that multiple periods of seclusion have not been used in quick succession as this may have the effect of detention.

Documentation should be reviewed to confirm that the above conditions are noted within the BSP. The APO must review and provide (or not) endorsement prior to forwarding to the SAO.

### 4.5.5 Environmental Restraint

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

Preventing access to an area that individuals are not ordinarily permitted to enter is not considered an environmental restraint. This is to reflect ordinary community standards of privacy and access that may occur in shared housing, workplaces, and community spaces and can include:

* 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.

Environmental restraint practices can have an impact on others who live in the same household or use the same facilities or residence, affecting their rights and freedom. When endorsing or authorising environmental restraints it is important to consider whether this will result in a restrictive practice being imposed on another person within the environment.

The Restrictive Practices Schedule provides APOs with further guidance regarding the specific considerations required for different types of environmental restrictive practices.

## 4.6 Making an Authorisation Decision

Where the APO makes the decision to authorise or endorse the use of a restrictive practice the APO must confirm that:

* + the NDIS participant is displaying behaviour that constitutes a risk of harm; **and**
  + the use of level 1 restrictive practices is necessary to minimise the risk of harm, or to prevent further harm from being caused; **and**
  + the NDIS participant has an NDIS Behaviour Support Plan. The BSP must be written by a behaviour support practitioner who is employed by an NDIS registered provider and deemed suitable by the NDIS Quality and Safeguarding Commission; **and**
  + the BSP was prepared in consultation with the NDIS participant; **and**
  + the use of level 1 restrictive practices of the relevant kind is contemplated by, and consistent with, the NDIS participant's BSP.

APO authorisation or endorsement decisions should be made within 10 working days of receipt of the request.

The maximum length of time that an APO can authorise any restrictive practice for is:

* 15 months from the start date of a comprehensive BSP.
* 8 months from the start date of an interim BSP.

An authorisation for a restrictive practice is linked to the behaviour support plan within which it was recommended. Where a new behaviour support plan has been developed for a participant, further authorisation must be sought by the implementing provider based on the RPs in the new plan (regardless of the authorisation end date of the previous authorisation).

APOs may authorise restrictive practice for a shorter period where:

* they believe this would be in the best interests of the participant, and
* the authorisation is required for immediate safety while further work is done to strengthen the behaviour supports that are provided to the NDIS participant.

It is important that APOs review any previous conditions of authorisation of the restrictive practice. Where there are previous conditions, APOs should:

* review whether the condition has been met
* where the condition has not been met, seek information about what actions were taken to meet the authorisation conditions

Where a condition would reasonably be able to be met by the implementing provider, it is expected that such conditions would be fully met before the restrictive practice is authorised for a further period.

Where a condition can only be met by another stakeholder such as the behaviour support practitioner or the guardian, the implementing provider is expected to take reasonable actions to facilitate the authorisation condition being met.

Where insufficient actions have been taken to meet the condition then APOs may consider not authorising the RP until the condition is met or making a short-term authorisation of the RP with additional conditions.

### 4.6.1 Further Information Required

Where an APO has identified gaps such as insufficient or incorrect documentation during the review of a request, the APO may return the request to the implementing provider to seek clarification, or further information. The APO should document these requests on the Restrictive Practices System to ensure there is a record of the communication related to the endorsement/ authorisation decision making process.

It is recommended that APOs make a phone call in the first instance to seek the information required and follow this up with written communication to ensure that there is a written record of any information provided to the APO that is used to determine an authorisation decision.

It is important that authorisation decisions or endorsements are not held up due to the request not meeting legislative requirements. Unless the issue can be resolved very quickly, the APO should consider not authorising the restrictive practice. The implementing provider can resubmit the request when all requirements have been met.

### 4.6.2 Authorisation With Conditions

APOs can authorise the use of a restrictive practice with conditions. An authorisation with conditions can be considered where:

* the BSP makes specific recommendations for the restrictive practice implementation (e.g., physical restraint to only be attempted by female staff)
* their assessment of the RP request and supporting materials identifies potential gaps in behaviour support for the NDIS participant
* further specialised advice is required to ensure that the behavioural interventions or the restrictive practice is least restrictive, safe to implement and the appropriate response or where regular reviews are required.

APOs should seek clarification or additional information in the first instance to attempt to resolve any issues prior to authorising a restrictive practice with conditions. APOs may contact the RPAT if they need assistance authorising a restrictive practice with conditions.

Common conditions added to authorisations include:

* A medical review to occur within the authorisation period, providing the prescribing doctor with details of the frequency, duration, and intensity of the behaviour of concern and frequency of use of the PRN medications.
* A detailed reduction and elimination plan to be developed during the authorisation period that includes the behavioural indicators that would prompt a reduction in the restrictive practice.
* Skill development strategies to be trialled and documented within the plan that work towards developing a functionally equivalent replacement behaviour.
* Develop a protocol for the use of the restrictive practice that supports workers to safely use the restrictive practice.

### 4.6.3 Not Authorised

Where the APO makes the decision not to authorise a specific restrictive practice the APO must provide reasons for their decision. Reasons the APO may not authorise or endorse a restrictive practice include:

* there are no behaviours that cause a risk of harm
* there is no current NDIS Behaviour Support Plan
* the restrictive practice being requested is not the least restrictive option available to mitigate or minimise the risk of harm
* the restrictive practice being requested is not consistent with the BSP or is not identified within the BSP
* no consultation was undertaken with the participant.

To ensure procedural fairness, the APO should engage with the implementing provider to attempt to resolve these issues (including returning the request to the requestor), where possible, prior to the restrictive practice not being authorised (Level 1).

### 4.6.4 Endorsement

APOs play an important quality assurance role for their organisation in supporting the organisation to meet the legislative requirements for a Level 2 restrictive practice request. By endorsing a request, an APO is confirming that they agree the restrictive request is appropriate and meets the legislative requirements. However, the SAO remains the legal decision maker for Level 2 restrictive practices.

APOs who have positional authority within their organisation may return applications to the applicant for further information or follow up work. Where the APO does not have the authority to require further work, the APO may decide not to endorse a decision.

Once the APO has made an endorsement decision, they must forward the Level 2 restrictive practices to the SAO for an authorisation decision.

### 4.6.5 Revocation

The Senior Authorisation Officer may vary or revoke a restrictive practice authorisation or a condition. A revocation may occur when:

* a restrictive practice authorised by an APO has been reviewed by the SAO due to an appeal and the authorisation did not meet the legislative requirements for authorisation
* a restrictive practice authorisation is audited by the SAO and the authorisation did not meet the legislative requirements for authorisation
* the restrictive practice is a prohibited practice
* the restrictive practice had time limited conditions that have not been met within the timeframe set out in the condition.
* any other reason which the SAO believes reasonable.

These are reviewable decisions under the legislation and can be appealed to SACAT.

### 4.6.6 Authorisation Not Required

The Restrictive Practices System allows for the recording of the status “authorisation not required” by the SAO. This status may be recorded when:

* the restrictive practice requested is not a regulated restrictive practice under the scheme
* the restrictive practice is already authorised under another legal authority (such as a SACAT order for detention)
* the restrictive practice is not used by the implementing provider.

### 4.6.7 Statement of Reasons

APOs are encouraged to keep detailed documentation of their decision-making process. Recording the decision-making process:

* improves the quality of decisions
* provides greater transparency and accountability in the decisions that are made
* ensures that all requirements have been met
* enables those affected by the decisions to decide whether the decision has been lawfully made.

The APO should record how they have applied the legal thresholds set by the Act, the Regulations, and Guidelines in their assessment of the person’s BSP and supporting documentation

Details of an APOs decision-making process may be requested by interested parties or by the SAO. The provision of this information to interested parties is crucial to determine how the decision was made, what information was considered and whether there needs to be further enquiry.

The [Statement of Reasons](https://www.sa.gov.au/__data/assets/word_doc/0009/778716/Statement-of-reasons-restrictive-practices.docx) has been developed for APOs to use when making an authorisation decision. This template provides a decision-making process for the APO to follow, and a way to record the process in one document that can be easily accessed if required in the future. The statement of reasons can be uploaded to the RPS. See the [Restrictive Practices System Guide – Record and Authorisation Decision](https://www.sa.gov.au/__data/assets/pdf_file/0007/783178/RPS-Guide-record-an-authorisation-decision.pdf) for details on how to do this.

## Recording Endorsement and Authorisation Decisions

### 4.7.1 Recording Authorisation Decisions on RPS

APOs are required to record their endorsement or authorisation decision in the Restrictive Practices System. Detailed instructions on this process can be found in the [Restrictive Practices System – Record an Authorisation Decision](https://www.sa.gov.au/__data/assets/pdf_file/0007/783178/RPS-Guide-record-an-authorisation-decision.pdf)

Documentation of endorsement and authorisation decisions within the RPS allows APOs to meet their legal obligation under Regulation 11 (2) to advise the SAO of their Level 1 authorisations every 6 months. The RPU extracts data from the RPS to review endorsement and authorisation decisions made by APOs as part of our quality assurance, compliance, and auditing processes.

### 4.7.2 Evidence of Authorisation Decisions

Section 23N (2) of the Act requires APOs to provide their authorisation decisions in writing, including:

* whether the authorisation is conditional or unconditional
* the kind of restrictive practice(s) being authorised
* the date that the authorisation ceases.

The Restrictive Practices System can generate an authorisation statement once an authorisation decision is recorded.

Implementing providers should provide the authorisation statement to the participant and their legal guardian, either in its original form or in a way that the NDIS participant can understand the decision that has been made. Further information regarding implementing provider’s obligations can also be found within the [Restrictive Practices Manual for Implementing Providers](https://www.sa.gov.au/topics/care-and-support/disability/restrictive-practices/resources/providers-and-apos).

### 4.7.3 Restrictive Practices No Longer Required

Authorised restrictive practice may be faded out or no longer used for a number of reasons. Authorisation decisions are point in time decisions that are made based on the restrictive practices identified within a behaviour support plan that meet the legislative requirements for authorisation.

Where a restrictive practice is no longer required the authorisation decision is not changed on the Restrictive Practices System. This is because the RPS needs to reflect the authorisation decision that was made at the point that the restrictive practice authorisation was requested.

## Dispute Resolutions and Reviews

The APO should provide their organisation’s internal dispute resolution and complaints process to any interested parties on request. APOs will work collaboratively with interested parties and attempt to resolve internal complaints where possible.

People who are aggrieved by the decision of the APO must be informed of their rights to appeal to the SAO (section 23 (Y) (1)).

Implementing providers are required to provide participants and their guardians with information about the appeal process. Further information regarding this requirement can be found in the Restrictive Practices Scheme Manual for Implementing Providers.

Information about complaints and appeals for the Restrictive Practices Authorisation scheme can be found on the Restrictive Practices website.

The APO must also provide information regarding their decision-making process to interested parties or to the SAO upon request.

# Glossary

|  |  |
| --- | --- |
| **Authorised Program Officer (APO)** | Implementing provider staff member who has been authorised by the Senior Authorising Officer to authorise Level 1 restrictive practices. |
| **Behaviour Support Plan (BSP)** | Behaviour support plans document the assessment and interventions to assist the person with disability, their families, carers, and professionals to support them in an agreed and consistent way, including strategies to mitigate behaviours of concern and reduce or eliminate restrictive practices. The Act requires that BSPs within the Scheme meet the requirements of the NDIS Rules and includes both interim and comprehensive behaviour support plans. |
| **Behaviour Support Practitioner** | A behaviour support practitioner who is employed by an NDIS registered provider and deemed suitable by the NDIS Quality and Safeguarding Commission |
| **Endorsement** | The process of an APO reviewing a level 2 restrictive practice authorisation request to ensure that it meets the legislative requirements for authorisation prior to submission to the SAO. |
| **Implementing Provider** | The NDIS registered provider that will be using the restrictive practices once authorised. |
| **Level 1 Restrictive Practice** | A restrictive practice that can be authorised by an Authorised Program Officer. Details of whether a restrictive practice is a Level 1 can be located in the Regulations and the [Restrictive Practices Schedule](https://www.sa.gov.au/topics/care-and-support/disability/restrictive-practices/resources/providers-and-apos). |
| **Level 2 Restrictive Practice** | A restrictive practice that must be authorised by the Senior Authorising Officer. Details of whether a restrictive practice is a Level 2 can be located in the Regulations and the [Restrictive Practices Schedule](https://www.sa.gov.au/topics/care-and-support/disability/restrictive-practices/resources/providers-and-apos). |
| **Participant** | An NDIS participant who is subject to a restrictive practice under the Restrictive Practices Scheme in South Australia. |
| **NDIS participant** | The term given for an NDIS participant within the Act and the Regulations. |
| **Prescribed Provider** | The term given for an implementing provider within the Act and the Regulations. |
| **Regulated Restrictive Practices** | Restrictive practices that are regulated by the Restrictive Practices Authorisation Scheme under the Disability Inclusion Act 2018. There are minor differences between these regulated restrictive practices and those that are regulated by the NDIS Commission under the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018*. |
| **Restrictive Practice** | Any practice or intervention that has the effect of restricting the right or freedom of movement of a person with disability, with the primary purpose of protecting the person or others from harm. Some restrictive practices are not regulated by the Restrictive Practices Authorisation Scheme or the NDIS Commission. |
| **Restrictive Practices System** | The South Australian web-based system that enables restrictive practice authorisation requests to be submitted by implementing providers and authorised by Authorised Program Officers or the Senior Authorising Officer. |
| **Restrictive Practices Authorisation Scheme** | The scheme that manages the authorisation of restrictive practices in South Australia under the Disability Inclusion Act 2018 (as amended by the Disability Inclusion (Restrictive Practices—NDIS) Amendment Act 2021). |
| **Revoked** | A decision made by the Senior Authorising Officer to rescind an authorising decision made by an Authorised Program Officer. A revocation may occur when:   * A restrictive practice authorised by an APO has been reviewed by the SAO due to a request for appeal and the authorisation did not meet the legislative requirements for authorisation * A restrictive practice authorisation is audited by the SAO and the authorisation did not meet the legislative requirements for authorisation * The restrictive practice is a prohibited practice * The restrictive practice had time limited conditions that have not been met within the timeframe set out in the condition. * Any other reason which the SAO believes reasonable. |
| **Senior Authorising Officer (SAO)** | The person appointed to the position of the Senior Authorising Officer, which has the following functions:   * to assist the Minister in the preparation, variation, or substitution of the restrictive practices guidelines * to keep the restrictive practices guidelines under review * to authorise specified persons to authorise the use of level 1 restrictive practices by a prescribed NDIS provider * to authorise the use of level 1 or 2 restrictive practices (or both) * to promote the reduction and, where possible, the elimination of the use of restrictive practices in the disability sector to provide education and training relating to the use of restrictive practices * to advise the Minister and other persons in relation to the use of restrictive practices in the disability sector |

# Document Control

|  |  |
| --- | --- |
| **File Number** |  |
| **Applies to** | Authorised Program Officers |
| **Issued by** | Restrictive Practices Unit |
| **Content author (position & phone no)** | Senior Authorising Officer |
| **Implementation Date** |  |
| **Confidentiality** |  |

## Table 2 – Revision Record

|  |  |  |
| --- | --- | --- |
| **REVISION RECORD** | | |
| Date | Version | Revision Description |
| July 2022 | 1.0 | First publication |
| July 2023 | 2.0 | Amendments to the Manual to provide greater clarity to APOs in the undertaking of their role within the Scheme based on feedback from the first 12 months of the implementation of the scheme. |