JFA
Purple Orange

Minimising and Eliminating Restrictive Practices. A Consultation for the ACT Government
Final Report

June 2017

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JFA Purple Orange is a non-government, social profit organisation. Anchored on dialogue with people living with disability, their families, service providers, government and other stakeholders, we seek to identify policy and practice that has the prospect of advancing peoples chances of a good life. Our work is anchored on the principles of Personhood and Citizenhood. Our work includes research, evaluation, capacity building, consultancy, and hosted initiatives.

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Contents

1. Purpose of this report

The purpose of this document is to offer a final report following a community consultation led by JFA Purple Orange on how an Office of the Senior Practitioner might operate in the ACT. A discussion paper released in January 2017 gives an overview of what is meant by restrictive practices, the extent to which such practices are an issue in the ACT, and how these issues might be addressed through an Office of the Senior Practitioner. From late January to March 2017, a range of opportunities were offered for people to give their views about this topic during Phase 2 of a staged consultation project. A second report prepared in March 2017 provides a set of possible features and components that could be considered should adoption and design of an Office of the Senior Practitioner be undertaken by the ACT government. Both the initial discussion paper and the Phase 2 report are available publicly on the website www.actopsp.org.au.

The current report is the final report for this project and offers several key sections to inform the ACT government of relevant findings. These include:

1. an overview of processes across jurisdictions in Australia relating to restrictive practices;
2. an overview of Phases 1 & 2 of this consultation process;
3. an evaluation of findings from consultations with key stakeholder groups in Phase 3 of this project;
4. final recommendations and options for the ACT Government regarding possible models for establishing an Office of the Senior Practitioner inclusive of a proposed stepped timeline for coordination.

For the purpose of this project the definition of restrictive practices offered by the Government of South Australia has been utilised:

> *Restrictive practices refer to any practice, device or action that removes or restricts another person's freedom, movement or ability to make a decision. This includes detention, seclusion, exclusion, aversive restraint, chemical restraint, physical restraint, mechanical restraint, environmental restraint and psycho-social restraint. Restrictive practices do not include therapeutic or safety devices/practices, where the device or practice is being used for its intended purpose and the person is not resisting or objecting to its use*[1].

Restrictions can include (but are not necessarily limited to):

- ***mechanical***, such as devices that limit a person's movements (and this includes the removal and/ or disengagement of mechanical supports that assist the person's movements)
- ***seclusion,*** such as the sole confinement of a person at any time in any room where the doors and windows cannot be opened by that person

[1] SA Government DCSI Safeguarding People with Disability Overarching Policy

- ***environmental,*** such as preventing free access to all parts of a person's environment or house (for example locking the refrigerators)
- ***social***, such as the imposition of sanctions that restrict the person's access to relationships/opportunities they value
- ***chemical***, such as medications that blunt the person's emotions, cognition, and motor activity
- ***physical***, such as holding or 'pinning down' by another person
- ***psycho-social restraints,*** such as power control strategies[2] which might include threats, intimidation, fear, coercion, discipline, or retaliation
- ***organisational,*** such as excluding the person from activities, and restrictions to the person's choice
- ***communication restraint,*** such as switching off someone's communication device
- ***decision making restraint,*** such as failing to provide options for supported decision making

While taking action to avert a clear and present risk of harm is understandable, there are a number of problems with the imposition of restrictive practices. These include (but are not necessarily limited to):

- the negative consequences the restrictive practice by its nature can have on the person's progress towards good life chances, their general well-being, physically and psychologically including the impact on self-esteem
- restrictive practices that are focused on behaviour suppression as opposed to supporting genuine positive behaviour change
- restrictive practices that are inadequate in terms of their conceptualisation and implementation
- restrictive practices that are inadequate in terms of a clearly defined timeframe and process for review
- restrictive practices that constitute an assault on the person's human rights
- restrictive practices that are crafted and/or executed by staff with inadequate skills and perspective.

It is recognised that the use of restrictive practices may not always be intentional but that actions taken, or not taken, inadvertently have the effect of restricting a person's preferences and actions, and/or contravening their rights. The person using the restrictive practice may argue that there is no malicious intent and that it is just the way that things are done. However, this is not an adequate defence for the continuation of such practices.

[2] Power-control strategies' are defined in South Australia's *Safeguarding People with Disability Restrictive Practices Policy* as "the use of power-control strategies to influence a person's behaviour. This includes but is not limited to directing the person's behaviour through voice tone, commands or threats and the use of punishment, including ignoring the person and withholding basic human rights, such as positive social interaction, personal belongings or a favoured activity."

2. Summary

This community consultation was undertaken to hear community stakeholder views about the nature and extent of restrictive practices in the ACT, and how an ACT Office of the Senior Practitioner ('ACTOSP') might help. The consultation included the public, plus peak bodies and their members relevant to advocacy or service provision in the human services industry, plus other consumer/service perspectives, plus government services, plus statutory post holders.

From the three phases of consultation conducted, covering the period from November 2016 to June 2017, it is clear that community stakeholders do see the use of restrictive practices as an issue in the ACT. This does not mean this is a greater issue in the ACT compared to any other jurisdiction, but that it is an issue that needs to be addressed.

It is also clear that community stakeholders can see benefits in the establishment of an ACTOSP.

The community consultation was augmented by an examination of how other Australian jurisdictions approach the control of restrictive practices, and what might be learnt from that about which elements might best suit the ACT context.

The subsequent analysis identified three main role considerations for how an ACTOSP might lead the safe removal of restrictive practices:

- ***Regulate***, which contemplates how an ACTOSP might influence decisions about whether a service agency uses restrictive practices;
- ***Adjudicate***, which contemplates how an ACTOSP might contribute to the investigation of concerns about restrictive practices being used, and the issuing of orders to desist such practices
- ***Facilitate,*** which contemplates how an ACTOSP might contribute to raising awareness about restrictive practices and their alternatives, and how to systematically build sector capacity towards those alternatives.

In relation to *Regulate*, the report proposes an arrangement whereby an ACTOSP establishes and disseminates a best practice framework for the way service agencies decide whether to use restrictive practices, anchored on the quality of support planning with the person, and how any agency decisions to use restrictive practices are stored, analysed and reported.

In relation to *Adjudicate*, the report proposes an arrangement where best use is made of existing agencies with investigation mandates within the ACT, where an ACTOSP assists those agencies capacities in relation to uncovering unacceptable restrictive practices, and where an ACTOSP has the mandate to issue an order that disallows an unacceptable practice. The report also proposes an ACTOSP carrying direct investigative capacity in relation to a complaint about a service agency's decision about restrictive practices, and in relation to undertaking a systemic review of a service agency where there have been a series of complaints and reports about unacceptable restrictive practices.

In relation to *Facilitate*, the report proposes an arrangement where an ACTOSP takes a lead role in designing and implementing a sector-wide strategy for raising awareness about, and building service agency capacity towards, positive alternatives to restrictive practices. In addition, the report proposes that an ACTOSP have in-house specialist expertise to directly contribute to this capacity-building, together with the resource capacity to commission research and initiatives that help find alternatives to restrictive practices.

The report proposes that the arrangements would apply to all human service settings in the ACT, including, but not necessarily limited to, disability support, education, health including mental health, and aged care.

The report also notes the importance that the balance of investment in an ACTOSP, and its corresponding culture, is weighted in favour of sector capacity-building rather than just pursuing compliance.

The report proposes that an ACTOSP be established within an existing organisation in the ACT, and not one that is involved in commissioning or delivering services. The report also sets out a sample implementation timeframe, and proposes there be an implementation advisory group, and that such a group comprise the range of stakeholder perspectives.

Below are listed the specific recommendations that appear in this report from section 9 on.

Recommendation 1
That the ACT Government establish an Office of the Senior Practitioner ('ACTOSP') to provide leadership and oversight across all types of service operating in the ACT where restrictive practices may be operating, with the goal of avoiding, reducing and eliminating restrictive practices, in favour of positive alternatives that preserve the individual person's rights and freedoms.

Recommendation 2
That legislation is established to require all service agencies working with vulnerable people in the ACT, to run restrictive practice oversight standards, and that these standards be established and curated by the ACTOSP

Recommendation 3
That the ACT Government establishes a data capture and reporting mechanism, to be curated by the ACTOSP, for the conduct of restrictive practices, and consider the economies and synergies that may be gained from negotiating access to an existing relevant database, in preference to an ACT design-and-build

Recommendation 4
That the role requirements of existing investigative arrangements operating in the ACT be updated to include detailed insights into the nature and manifestation of restrictive practices, and that the ACTOSP role include a provision to provide capacity-building support to those investigators

Recommendation 5
That the ACTOSP role include the mandate and capacity to undertake systemic investigation on reasonable grounds of the practices of any service agency operating in the ACT, with the primary goal of advancing that agency's capacity to use alternatives to restrictive practices

Recommendation 6
That the ACTOSP role includes the mandate and capacity to issue an order to a service agency to discontinue a restrictive practice

Recommendation 7

That the ACTOSP role includes the mandate and capacity to develop and lead an ACT-wide strategy to raise awareness about restrictive practice and to build capacity in support of alternatives

Recommendation 8
That the ACTOSP role include capacity to directly provide specialist input to agencies in relation to alternatives to behaviour support, and to develop other best practice materials that assist service agencies to build capacity

Recommendation 9
That the ACTOSP role include budget capacity to fund initiatives that can help safely remove restrictive practices

Recommendation 10
That the ACT Government, or the ACTOSP as soon as possible following its establishment, resolves a clear and documented working relationship with the NDIS in respect of at least the following:

1) the establishing and curating of best practice guidelines relating to the development of support plans that minimise/avoid use of restrictive practices,

2) the storage, analysis and reporting of restrictive practices data

3) the receipt of complaints about restrictive practices in NDIS-funded services

4) the initiation and conduct of specific investigations and/or systemic reviews of agencies where restrictive practices are a concern

5) the disallowance of unacceptable restrictive practices following such investigations

6) the initiation of a review of the costs of an individual support package, to ensure it includes the reasonable costs of delivering alternatives to restrictive practices

7) the leadership, strategy and funding of capacity-building activities to service agencies to adequately install reasonable alternatives to restrictive practices.

Recommendation 11
That the ACT Government consider locating the ACTOSP within an existing authority operating in the ACT and that is independent of service provision/commissioning

Recommendation 12
That the ACT Government considers establishing a multi-stakeholder advisory group to provide advice and support to the ACTOSP.

Recommendation 13
That any staged implementation of ACTOSP ensures a robust investment in capacity-building activities relative to compliance activities

3. Structure of this report

This report serves as the final report following the Phase 3 consultation process and a thorough data analysis. We have focussed in this report on using content gained from consultations to inform the possible role of an Office of the Senior Practitioner within the ACT. The interim report published in March 2017 addresses the key conceptual elements relating to establishing an OSP within the ACT. This report adds detailed operational considerations of establishing an oversight body for minimising and eliminating restrictive practices in the ACT, such as a scoped pathway for each identified element of OSP roles, discussion of the main interface issues, and suggested solutions to the main interface issues.

4. Summary of methodology

4.1. Consultation participants

More than 70 individuals contributed to this project, via survey, phone or face-to-face consultations. All participants represented key stakeholder groups across the ACT sector including consumers, sector workers and organisational leaders.

4.2. Consultation Design

This consultation project took the approach of a series of consultations informed through survey, phone and in-person consultations using a co-design methodology. Key stakeholder groups across the ACT sector were invited to join as members of a co-design group. The advantage of design-driven forms of research and evaluation such as co-design methodology allow the use of flexible and creative tools that capture reflection and sharing from participants. For example, the use of shared story building and process mapping via whiteboards or sticky notes was applied regularly across these consultations. Unlike traditional established styles of research that rely on systematic data analysis, a co-design method does not force the use of a rigorous approach. Therefore, creative and interactive tools can be utilised within sessions with participants and this can allow for very rich data to be captured and subsequently analysed.

5. Summary of other Australian jurisdictional arrangements for overseeing restrictive practices

A rigorous review process was undertaken by JFA Purple Orange between January and June of 2017. Currently, the various Australian governments have differing approaches to the issue of restrictive practices. Where possible, the full extent of provisions in each jurisdiction is detailed, inclusive of legislative, regulatory, policy and practice arrangements in each jurisdiction. In addition, these arrangements have been examined in terms of the extent to which they apply to one or more of differing demographics such as mental health, disability, older persons, children and young people, people in touch with the justice system, and also across a range of public service areas such as human rights, education, health, etc. It seems necessary to offer a complex review within this report such that our recommendations can be couched within the knowledge and context from other jurisdictions.

We note the Australian Law Reform Commission's recommendation that because of the range of variation across the Australian jurisdictions, there is a case for a common framework[3].

This section therefore provides in-depth exploration of the processes in which other Australian states and territories have adopted for managing restrictive practices.

5.1. Victoria

In Victoria, the Senior Practitioner (Disability) is responsible, under the Disability Act 2006, for ensuring that the rights of persons who are subject to restrictive practice are protected and that appropriate standards are complied with.

What are the roles and functions of the Senior Practitioner?

- educating service providers
- facilitating knowledge and training
- monitoring the use of restrictive practice in disability services.

The Senior Practitioner can:

- visit and inspect any disability service
- investigate any use of restrictive practice
- direct a service provider to stop using a restrictive practice.

[3] Australian Law Reform Commission's paper *Equality, Capacity and Disability in Commonwealth Laws*

https://www.alrc.gov.au/sites/default/files/pdfs/publications/whole_dp81.pdf

What approvals are required in relation to restrictive practices in Victoria?

Providers wishing to use restrictive practices require approval and oversight by Authorised Program Officers or the Senior Practitioner.

What reporting occurs?

The Disability Act establishes reporting obligations and external review mechanisms of this process for The Office of the Senior Practitioner in Victoria

Victoria also has the Restrictive Intervention Data System (RIDS) which has been developed to record and report events of routine, PRN or emergency restrictive interventions such as chemical restraint, mechanical restraint or seclusion. An annual report is released by the Senior Practitioner for each financial year.

What types of capacity building does this office carry out?

The Senior Practitioner's office shares expertise and raises awareness of restrictive practices through advice, partnerships and consultation with our stakeholders.

Examples of activities include:

- Senior Practitioner seminars
- Compulsory treatment practice forums
- Compulsory treatment practice newsletters
- Dissemination of publications and conference presentations

5.2. Tasmania

In Tasmania the Senior Practitioner is appointed by the Secretary of the Department of Health and Human Services (DHHS) under the Disability Services Act 2011.

What are the roles and functions of the Senior Practitioner?

- advice to the Department and the Guardianship and Administration Board about the use of restrictive practice
- develops guidelines and standards
- provides accessible information about the rights of people with disability.

The Senior Practitioner can visit service providers and look at how and why a restrictive practice is being used.

What reporting occurs?

Reporting obligations and external review mechanisms are established by The Disability Act for this process. This includes an annual report that provides information on the performance of the functions, and the exercise of the powers, of the Senior Practitioner during the previous financial year; and data relating to the use of restrictive interventions. The data indicates some trends that

require further examination by the Senior Practitioner in her role of developing guidelines and standards in accordance with best practice in the disability sector, and related to the incidence of use of restrictive interventions.

The annual report also outlines the activities conducted by the Senior Practitioner and makes recommendations about the provision of specialist disability services as well as in the regulation of use of restrictive interventions.

What approvals are required in relation to restrictive practices in Tasmania?

Providers wishing to use restrictive practices require from the Guardianship and Administrative Board for personal or environmental restriction.

What types of capacity building does this office carry out?

The Senior Practitioner carries out a number of capacity-building tasks in relation to restrictive interventions including:

- developing guidelines and standards
- providing education and information
- providing information as to the rights of people with disability
- providing advice to the Secretary, the Guardianship and Administration Board, disability service providers and funded private people to improve practices
- Undertaking research, observations and evaluations.

5.3. South Australia

In South Australia, the Office of the Senior Practitioner sits within the Department of Communities and Social Inclusion (DCSI). The Disability Services Act (1993) has provisions for safeguarding policies and procedures including restrictive practices. The Guardianship and Administration Act (1993) provides for special powers orders to be made in relation to residence and/or detention and/or treatment and care of a person with a mental incapacity.

What are the roles and functions of the Senior Practitioner?

- awareness raising and training
- promotion of positive behaviour support practices.

The Office of the Senior Practitioner has a key focus on the minimisation and where possible, elimination of restrictive practices within disability services.

The Senior Practitioner is finalising procedures to ensure disability service providers are responsible for accurate recording and reporting of the use of restrictive practices by maintaining a register and recording every use of restrictive practice.

What approvals are required in relation to restrictive practices in South Australia?

It is required that approval is gained via informed consent of an adult person with a disability with mental capacity. Consent of a parent or guardian is required for children with disability.

Under section 32 of the Guardianship and Administration Act 1993, an order by the SA Civil and Administrative Tribunal is required authorizing a restrictive practice where a person does not have mental capacity to consent.

What reporting occurs?

There are no reporting mechanisms however the South Australian Civil and Administrative Tribunal reviews orders at regular intervals in accordance with legislation and revokes orders unless proper grounds for the order remains.

What types of capacity building does this office carry out?

The SA Senior Practitioner devotes a great deal of time towards capacity building and awareness raising strategies:

- Training packages
- Meet with organisations
- Developmental seminars
- Resources that outline alternative practices

5.4. New South Wales

In NSW the Office of the Senior Practitioner Ageing, Disability and Home Care sits within the Department of Family and Community Services (FACS) NSW. Whilst high level principles and objectives exist within relevant legislation this is not restrictive practice specific. Instead there are policy level requirements related to the use of restrictive practices within New South Wales. The use of restrictive practices therefore is essentially governed by the FACS Department's behaviour Support Policy and Practice manual with main principles governing rights of people with disability in the Disability Inclusion Act 2014.

What are the roles and functions of the Senior Practitioner?

The Senior Practitioner provides leadership and coordination of services for people with complex needs and challenging behaviour. This is inclusive of adults, children and young people with an intellectual disability.

Restrictive practices are managed through a Behaviour Support Plan, which is completed by a senior clinician (e.g. psychologist). Depending on the complexity of the issue, the matter is referred to the Behaviour Support Team, a district wide service for adults with disability and children with disability not under the care of the Minister.

What approvals are required in relation to restrictive practices in New South Wales?

If a Restrictive Practice is recommended by a clinician then it needs to be approved by a consenting authority (e.g. informed consent of person or their guardian). Approval is required under providers' Internal Authorization mechanism

A Restrictive Practices Panel exists, comprised of members from the statewide/district wide Behaviours Support team. This panel also consists of some independent members from other disability service providers.

A plan is then submitted with detail of how the Restrictive Practice will be implemented alongside an attempt to phase it out (e.g. a "drop down"). Plans are approved for 3, 6, and 12 months. They then go back to the panel for further review after this time period.

If there is a safety concern and a reason for a restrictive practice to be implemented in a hurry (such as a locked door to prevent running out into an unsafe situation (e.g. road), then there is a fast-tracked interim approval process that can be undertaken by a senior clinician.

What types of capacity building does this office carry out?

The Office of the Senior Practitioner (OSP) is the first time the Department has had a specific unit dedicated to practice leadership. The role of the office is to promote good practice, inspire, support and review the work of the frontline.

Since it started the OSP has been rolling out a new framework for child protection and out of home care service delivery called Practice First. The framework is now operational in 45 per cent of frontline offices across New South Wales and early data show a decline in re-reporting rates and a decline in entries into care.

5.5. Queensland

Queensland does not have an Office of the Senior Practitioner. On 1 July 2014, new legislation (amendment to Disability Services act 2006) came in to place to ensure the use of positive behaviour support and to protect clients who may be subject to restrictive practices.

The new laws also make it easier for disability service providers to meet their legal obligations, while increasing their accountability around the use of restrictive practices. Additionally, the changes include streamlined processes to allow service providers to focus on supporting their clients.

The new process entails five steps for disability service providers. The approvals process depends on what type of restrictive practice is being used and whether it is a short-term or long term response:

- Step 1 – develop a positive behaviour support plan
- Step 2 – identify any restrictive practices in use
- Step 3 – provide the adult and stakeholders with a statement about the use of restrictive practices
- Step 4 – make a short-term approval application(where there is an immediate and serious risk of harm) to the Public Guardian or the Chief Executive, Department of Communities, Child Safety and Disability Services
- Step 5 – seek approval from Queensland Civil and Administrative Tribunal (QCAT) for long term use, implement and review the plan.

The Queensland Government has committed to delivering training programs throughout the state through the Centre of Excellence for Clinical Innovation and Behaviour Support.

5.6. Northern Territory

The Northern Territory does not currently have an Office of the Senior Practitioner. The regulation of restrictive practice is contained within the Disability Services Act 2015

5.7. Western Australia

WA does not have an Office of the Senior Practitioner. Regulation is through the Disability Services Act 1993 and the Code of Practice for the elimination of Restrictive Practices.

5.8. National initiatives

The NDIS Safeguarding Quality and Safeguarding Framework suggests that a National Office of the Senior Practitioner could be established across Australia in the near future.

It is recognised that while the NDIA is considering a nationally appointed Senior Practitioner to monitor and review the use of restrictive practices, this remit would be limited to restrictive practices occurring in the context of disability. This does not cover people living with increased vulnerability in other contexts such as mental health specific contexts, education settings, aged care settings or custodial settings. Therefore it is still imperative that the ACT consider local oversight arrangements towards the monitoring and reduction of restrictive practices.

5.8.1. Potential role of a National NDIA Senior Practitioner

It is expected that legislation for a national Senior Practitioner role will be passed in the latter part of 2017. This newly-established national role will be designed around the approach of monitoring and providing support to NDIS participants. Under this approach, the National Senior Practitioner will not provide any authorisation or approval for the use of restrictive practices; rather the approval process will always occur at state or territory jurisdiction level.

It is proposed that a provider wanting to implement restrictive practices into a NDIS Participant's support plan will now be forced to become an NDIS provider under this new framework. The key responsibilities of the National Senior Practitioner for the NDIA will include:

- to set up a register of Positive Behaviour Support accredited NDIS providers
- to assist providers in terms of best practice
- to provide oversight and monitoring of restrictive practices for NDIS participants.
- to have very close operational linkages between all OSPs across Australia.
- to develop a framework of competency to assess practitioners re positive behaviour support
- to create a regulatory framework in which the National Senior Practitioner is responsible for education, and monitoring and overseeing the use of restrictive practice for NDIS participants via a nationally-established database. The Senior Practitioner would be engaged in a leadership role working with the states and territories to critically examine and share information through an accessible database.

6. Summary of key points from Phase 1

6.1. Stakeholders are concerned about restrictive practices

Significant concerns were raised that restrictive practices may be over-utilised in the ACT. However well-intentioned, there appears to be an established culture in the use of restrictive practices, for example in situations where service providers do not have, or cannot easily see, another avenue of response. This is likely due to a lack of capacity or opportunity for service providers to develop and continually apply alternative strategies to restrictive practices, not just to one-off crisis situations but to situations which occur day after day, week after week.

The above comments are not intended as an indictment on service providers, who may be in struggle because of a lack of capacity within the organisation, and perhaps more broadly in the industry, for designing and delivering alternatives to restrictive practices. Nor are the comments intended to suggest that all service providers in the ACT are actively and regularly using restrictive practices. At the same time, nobody has disputed the presence of restrictive practices in the ACT (which means at least some providers are using restrictive practices), and nobody has disputed an assertion that it's a significant issue.

Perhaps the key point here is not that EVERY service provider is engaged in restrictive practices, but that ANY service provider is at risk of it. This may be due to one or more of a number of factors, including: lack of awareness about restrictive practices; imperfect support planning; confused values; funding drivers; funding levels; insufficient capacity at responding to complexity; calcified service culture; poor access to specialist expertise; group service structures; insufficient interest in or resourcing of capacity-building and reflective practice; poor leadership capacity and practice; and others. This doesn't make the service provider sector inherently bad, because it isn't. But it reveals the nature of the struggle, and it emphasises the importance of proactive action.

6.2. Stakeholders can see a role for an ACTOSP

Also from the phase 1 consultation, it seems clear stakeholders can envisage practical ways an ACTOSP can help reduce and eliminate restrictive practices. This set the scene for the phase 2 consultation, to explore what ways an ACTOSP could help safely reduce and remove the use of restrictive practices in the ACT.

7. Summary of key points from Phase 2

Following the consultations, data was analysed using thematic analysis to achieve a coded list of emerging themes. These findings are outlined in a previous discussion paper and comprise the major issues and concerns related to the use of restrictive practices across the ACT, possible solutions to these issues and the possible role and function of an ACT-based Office of the Senior Practitioner (ACTOSP) or similar oversight body. Table 1 below shows the main themes emerging from Phase 2 Consultations

TABLE 1	Main themes relating to restrictive practices in the Act and the establishment of an Office of the Senior Practitioner
Theme 1	A lack of awareness and consistency of what constitutes restrictive practices
Theme 2	Use of restrictive practices within mental health settings
Theme 3	A lack of capacity within the sector for managing behaviour and its etiology
Theme 4	The need for leadership that drives a strategy and culture change regarding restrictive practices across the sector
Theme 5	An issue with current reporting of the use of restrictive practices and a lack of long-term data
Theme 6	Differing opinions regarding the use of restrictive practices

Following analysis of the data captured within survey responses, consultations and submissions several design features have been identified as key recommendations for an ACT-based Office of the Senior Practitioner.

Awareness-raising activities, access to specialist advice and maintenance of a register from which regular reporting is undertaken were design elements that emerged through the process of consultations. Two different views were raised regarding the roles of an ACTOSP in relation to providing sign-off on the use of restrictive practices and providing a monitoring and investigation role. Some participants identified that an OSP could be given authority to provide sign-off to the use of restrictive practices, possibly in consultation with a review panel comprised of multidisciplinary members to inform decision-making. However, other participants suggested that any sign-off

authority should come from an external body (that is, not within an Office of the Senior Practitioner) and instead the ACTOSP should undertake the role of monitoring the use of restrictive practices and carrying out investigations.

It is recognised that there could be benefits with either approach taken. Certainly, if an ACTOSP were given authority to provide sign-off on the use of restrictive practices in individual cases then this is a specific function to be carried out accordingly by a dedicated office. However participants who saw that these two functions should be separated held the view that establishment of an external body to grant necessary sign-off and permission regarding restrictive practices would allow an OSP the position to manage roles of monitoring and investigation of the use of restrictive practices across the sector.

Box 2 provides an overview of all features.

BOX 2: Key design features for a future ACT Office of the Senior Practitioner

Design element	*Detailed description*
Awareness-raising and capacity building	A role within an Office of the Senior Practitioner to take the lead on awareness-raising around restrictive practices for the ACT and be a strategy leader around this
Specialist input	A system established whereby people working in the sector have access to a specialist for input into designing a plan around restrictive practices. This is to safeguard against a system whereby no assistance is provided to staff for developing a plan and then it is submitted to an Office of the Senior Practitioner and is requiring further information or refinement.
External sign-off and/or a role of monitoring and investigation	Two possibilities were raised: an Office of the Senior Practitioner in ACT could be given the ability to provide sign-off on cases involving restrictive practices- this decision process could be informed by a multi-disciplinary review panel. Alternatively, this role could be provided to an external body whilst an ACTOSP takes on the role of monitoring and investigating the use of restrictive practices across the sector.
Register and reporting function	An expectation that an ACT Office of the Senior Practitioner could undertake establishment and maintenance of a confidential register of restrictive practices, and that regular reporting on this data is released from the Office of the Senior Practitioner.

Consultation participants saw many roles and functions that could be performed by an ACTOSP. These include:

- Performing spot audits
- Oversee capacity-building and training programs around the use of restrictive practices in the ACT
- Building collaboration with key stakeholders within the pharmacist industry, which was a key recommendation from contributors representing the mental health sector

- Best practice alerts- the Office of the Senior Practitioner could put out regular alerts to industry (e.g. a weekly bulletin) to maintain regular conversation. This could provide regular communication with service providers around best practice in this space.
- Regular reporting- maintaining a register and reporting against this data would be useful to inform services of the scope of restrictive practices across the sector
- The OSP could be a well-informed independent voice to bring helpful attention to issues and opportunities across the Act sector. This could include opportunities to increase attention to: community values, capacity building activities and issues related to resources.

7.1. The potential role of an ACTOSP in leading practice in finding alternatives to restrictive practices

There are a range of people within the ACT community who may be affected by the use of restrictive practice. These include, but are not necessarily limited to, the following:

1. Children and adults living with disability
2. Children and young people in educational settings
3. Children and young people who have experienced trauma in the family home, or in separation from the family home, or in settings that substitute the family home
4. Older people
5. People experiencing enduring and episodic mental illness
6. People in justice-related custodial settings.

Given the known challenges associated with the purpose and consequences of restrictive practices, there is a clear imperative to build a more positive context for how people are supported, particularly people most at risk of a service provider using restrictive practices in their support arrangements.

Many participants felt that the anchor point for an ACTOSP should be around a Positive Behaviour Support framework and applied behavioural analysis. This is proposed on the premise that if the response to behaviour honours a person's choice then behavior is likely to stop. Individuals are usually angry because they want something different (e.g. often there is an environmental cause or trigger). Also, a number of contributors were clear that there will be many situations where the person is at risk of subjection to restrictive practices because they are angry or frustrated at being in current arrangements that do not reflect their choices. As such, the solution does not require a Positive Behaviour Support framework but instead a focus on honouring the person's choices. An ACTOSP could take the lead in awareness related to this issue.

Whatever the reason, there are two main steps that an ACTOSP can assist service agencies to engage:

Understanding the reasons

Where a person may be at risk of a service agency putting restrictive practices in place, it is of critical importance the service agency deepen its understanding of the person. This is particularly so if

there are concerns about the person placing themselves at risk, or placing others at risk, damaging property or being labelled in some way as disruptive.

It is important because people do things for a reason, and getting to know the person and their story will assist the agency in finding alternatives to restrictive practices.

Deeper insight to the person will better reveal the person's choices and preferences, and will also reveal the extent to which the person's current daily life is missing the opportunities that are meaningful to the person which bring that person into valued membership of community.

In their nature, restrictive practices undermine a person's choices and preferences, and can also undermine a person's chances of rich and meaningful life.

Alternatives to restrictive practices might include making changes to the person's support arrangements or home arrangements that better reflect the person's choices and preferences.

Building a positive alternative

There may be circumstances where people remain concerned about the person even where support arrangements better reflect the person's preferences and typical goals of community life, and where elements of restrictive practices are contemplated to manage acute situations where safety is a central issue.

In such situations, any restrictive practices need to be used sparingly, and always in the context of alternative types of support that preserve the person's preferences and life chances.

This raises the question about how to build support agency staff capacity to practice alternative approaches to restrictive practices, particularly where the solution lies beyond the honouring of someone's reasonable choices and preferences. These alternative approaches include positive behaviour support.

7.2. Growing the use of positive behaviour support

Positive behaviour support approaches are evidence-based and are an important element in assisting the life chances of someone with 'behaviours of concern'. This is because these approaches can help safely eliminate restrictive practices.

Positive Behaviour Support (PBS) arose in the 1980s in the context of emerging human rights and values-based approaches to disability support and in conjunction with the broader principles of applied behaviour analysis (ABA). This differs to the targeted ABA approach that is used as a form of early intervention for children with autism - which although uses the same behavioural principles, does not generally look at the person in their broader functional context. PBS is an approach, rather than a pre-determined list of strategies. Perhaps the clearest description of this approach has been most recently stated by Kincaid et al (2016 p.37)[4]:

[4] Kincaid, D., Dunlap, G., Kern, L., Lane, K., Bambara, L., Brown, F., Fox, L. and Knoster, T. (2016) Positive Behavior Support: A Proposal for Updating and Refining the Definition, Journal of Positive Behavior Interventions Vol. 18(2) 69–73

> "*PBS is an approach to behaviour support that includes an ongoing process of research-based assessment, intervention, and data-based decision making focused on building social and other functional competencies, creating supportive contexts, and preventing the occurrence of problem behaviours. PBS relies on strategies that are respectful of a person's dignity and overall well-being and that are drawn primarily from behavioural, educational, and social sciences, although other evidence-based procedures may be incorporated. PBS may be applied within a multi-tiered framework at the level of the individual and at the level of larger systems (e.g., families, classrooms, schools, social service programs, and facilities)*".

As such, the use of PBS relies on what is termed 'functional behavioural assessment', which involves a skilled practitioner working with key stakeholders. In collaboration, a multi-modal form of assessment is undertaken to gather historical and current information and observations to elicit an understanding of the underlying purpose of function of the behaviour. This approach allows for more targeted development of intervention strategies which can be clustered into four main categories: (1) antecedent and environmental strategies that are intended to reduce the context out of which problem behaviour arises and prevent behaviours of concern as much as possible; (2) skill building strategies, including the targeting of 'replacement skills' to help better equip the person to get their needs met in more adaptive ways; (3) contingency management strategies, which involves looking at what may have been previously reinforcing the behaviour and what the person's motivations are so that pay-offs for problem behaviour can be reduced and reinforcements for desirable behaviours can be increased; and (4) reactive and/or de-escalation strategies to assist with the safe management of incidents.

It is recommended that the above process needs to be implemented over a period of time, and in collaboration with stakeholders who are likely to be implementing the plan. A behaviour support plan is intended to guide staff and supporters. Plans should be monitored, reviewed and modified over time based on data and evidence of effect.

Unfortunately, positive support clinicians reported during this consultation that many plans can be 'incident management plans' which only address the last of these 4 areas and lack the holistic perspective required. This is perhaps a reflection that many agencies treat behaviour support planning as 'a template or document' that is used to mitigate risk and cover their duty of care to staff. However, to be effective, PBS really needs to be seen as a dynamic process for both the individual and staff and it needs to be strongly embedded into the culture of organisations as a valued process. This requires strong leadership, a supportive team environment and an overall culture across the ACT sector that prizes the merit and utility of this approach and provides capacity for staff to apply it.

8. Summary of key points from Phase 3 consultations

Phase 3 consultations were carried out with key stakeholder groups on design and implementation issues, including matters such as a process pathway, interface considerations with existing relevant offices and services, whether a clinically developed behaviour support plan should be mandatory, what roles, and functions and powers should an Office of the Senior practitioner have within the ACT.

Consultations were conducted during Phase 3 with key stakeholder groups including mental health, education, staff actively engaged in human rights, staff engaged in advocacy for people living with disability and increased vulnerability, service providers and disability sector representatives. Consultations were carried out in person, using a workshop style format to engage participants in technical conversations about possible models of an operational OSP for the ACT. Consultations on average lasted for 2 hours and up to 10 participants were involved in each session.

In particular, Phase 3 consultations focussed on establishing a mapped pathway for each scoped element of OSP roles, identifying the key interface issues between agencies and existing pathways, and scoping solutions to the key interface issues.

Before outlining the commentary provided by several stakeholder groups, we note the comment raised by a stakeholder during phase 3 that the incidence and prevalence of use of restrictive practices may be affected now that the ACT Government is no longer in the business of delivering disability services and, as such, means there is no longer a 'provider of last resort'. Sometimes, being a provider of last resort makes it more likely that the service population there is more likely to comprise people who have not been successfully supported elsewhere in the system, presumably because of their perceived complexity, including behaviours of concern.

This does not necessarily mean the providers of last resort carry are by default centres of excellence in providing alternatives to restrictive practices. Nor do the present report writers have sufficient information to establish a view on the reputation of the government's disability services and their 'last resort' specialist capacity.

However, if the ACT government was previously providing a 'last resort' role, this increases the urgency to strengthen the disability support service sector. This is because the 'last resort' service recipients are presumably now being served by different agencies, who may have less experience as a 'last resort' provider and, crucially, less capacity in the range of expertise that a best-practice 'last resort' should have in order to help people living with complex needs to move forward to better life chances.

8.1. Commentary from stakeholders engaged in service provision

A dedicated consultation was held in May with stakeholders engaged in disability service provision. The discussion was focused around establishing a desired pathway for the process related to

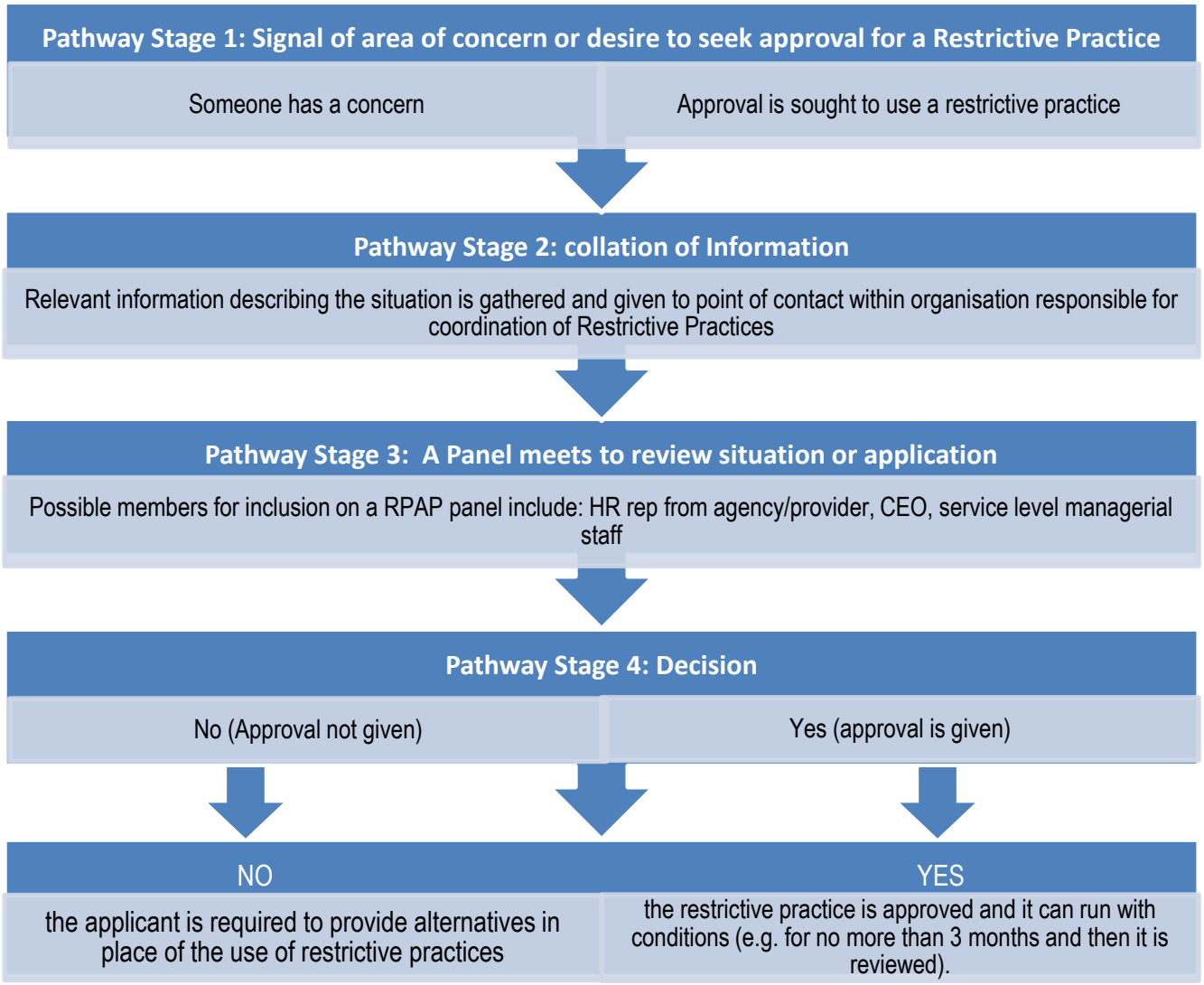
approving and monitoring restrictive practices. Further to that, participants gave insight of how an Office of the Senior Practitioner could be most helpful to sector workers in this stakeholder group.

The key design element of how an OSP could most efficiently help this stakeholder group was centred on the main function of the potential office. Participants suggested that developing an OSP that provided external sign off for approving the use of restrictive practices was not an efficient or desired approach. Rather, participants preferred that organisations within the service provision sector could establish and run their own Restrictive Practices Authorization Panels (RPAPS). Such panels are currently operating in other jurisdictions with success; for example, the National Disability Services (NDS) in New South Wales already have these panels in place. Within this model operating in New South Wales, the RPAP members are responsible for the running of the panel meetings including setting the agenda, circulating relevant documents prior to the meeting, maintaining confidentiality of all information given to the panel members, documenting and circulating the panel recommendations. The behaviour support practitioner who develops the documented support plan or the relevant manager responsible for implementing behavioural support is responsible for preparing the planned submissions.[5]

Participants at this consultation suggested that implementing this same model across the ACT disability service provision sector was likely to be successful.

A potential pathway was mapped out by the participants in the room during the consultation and the facilitator. This pathway is described in the following diagram.

[5] Restrictive Practice Authorisation Panel Workshop- safeguarding the rights of individuals learning guide. National Disability Services for Family & Community Services, New South Wales Government, 2015.



It was suggested that a strict timeframe for restrictive practices approvals should apply, with approvals never being for longer than 3 months. If an application comes around for the third time (e.g. after 1 renewal) then there should be a process implemented by which the RPAP directs it to an ACTOSP for an external review and recommendation.

8.1.1. Considerations associated with the proposed pathway

1. It would be necessary to engage a third party role for auditing. Participants at this consultations suggested that current examples from existing RPAPS in other jurisdictions reflect that an external party is commissioned to do a process order but not a content order.
2. If a particular agency is quite small then there could be the potential for agencies to band together for the sake of approving the use of restrictive practices. However issues related to confidentiality and ongoing working relationships in a competitive market might make this difficult. If this is the case then it seems pertinent to suggest that if an agency, provider or service organisation is quite small then a pathway needs to be established which provides them with access directly to the OSP in the ACT.

3. Participants considered that to make this proposed pathway work across the ACT then there might need to be an option for regulating service providers in the ACT. In this way, providers would expect an RPAP mechanism to be developed that is capable of being audited.
4. If agencies or provider organisations are too small to meet these requirements then it would be necessary to implement third party arrangements to access the ACTOSP in these cases.

8.1.2. Guidelines set out around RPAPS to include:

- Best Practice
- A clear definition with examples of restrictive practices across different contexts
- Clear and accessible checklists
- There should be access via an OSP to specialist expertise in restrictive practices or Positive Behavioural Support
- Guidelines could promote the use of laypeople (similarly to university ethics committees) who bring the viewpoint of a "reasonable person on the street". Such laypeople could have similar features to a Justice of the Peace. The guidelines might suggest for example that each RPAP panel needs to have two 'reasonable person" laymen who can represent different walks of life.
- Guidelines need to advise on how to establish panel members
- There is a need for guidelines related to PRN medications in the format of both a Best Practice Guide and in a Communities of Practice. There is significant need to build staff capacity around not abusing this or using it as a "first resort"

This model of an internal RPAP appealed to participants as it offers a robust option that sees decisions related to the use of restrictive practices being made within agencies. Furthermore, participants within this consultation recognized that this would be a low cost approach; the main task would lie in setting up guidelines for RPAPS and how to audit them.

8.1.3. Where might the ACTOSP interface?

- To draft RPAP guidelines and Best Practice "kit"
- Offer practice development via communities-of-practice- the sector needs to have ways to deepen their practice. An OSP could offer assistance to agencies to connect with each other.
- Undertaking monitoring and investigation roles
- Undertake audits by a senior practitioner (either as required or performed at regular intervals to inform practice and reporting)

8.1.4. What happens if the situation is urgent?

Participants considered what the best possible approach would be for matters of great urgency. The proposed pathway for an agency or provider would be the following 4 step approach:

1- Engage a Senior Manager (should be accessible even if out of hours)
2- Resolve a response
3- Notify the relevant RPAP panel chair
4- Review the situation afterwards (e.g. debrief and reflect as a team)

This final stage is especially critical. Participants involved in this consultation highlighted that a key issue for providers across the ACT sector is the need for reflective practice to be more deeply embedded in their work practices as a priority.

8.1.5. Exclusions or special considerations outside of regular RPAP pathway:

- There was a motion to exclude the issue of transportation safety from the regular approval pathway as this could prove onerous for a RPAP.
- Following recognition of externally crafted therapeutic plans/recommendations (e.g. a pharmaceuticals plan set by an external agent such as a GP or Psychiatrist) there is no need to seek permission to use therapeutic materials that have been set and mandated by other professionals.
- Therapy products such as bodysuits, Slippery Sams: a Body of Knowledge is required in this area. Such therapeutic materials should be externally provided but are restrictive in nature. Would need to run therapeutic pathways regarding this. Whilst this issue specifically is out of scope for current ACTOSP project, we need to mention in final report that such therapeutic materials are used by people for the therapeutic benefits/comfort even in the knowledge that they are restrictive. This can result in the users regarding these interventions as positive despite their restrictive nature.

8.1.6. Considerations associated with Guardian roles

- Guidelines are required in relation to situations when the guardian has a different point of view on utilizing a restrictive practice. To avoid confrontation with Service Providers and frontline leadership staff within the agency/provider, it is advisable to run a RPAP process for the situation. The family can then be supported to give their view and possibly personally present to RPAP. This format removes tension between family and frontline leadership.
- providers signaled that there could be an appeals process to an external mandated body
- There needs to be capacity for everyone to contribute to the collation of information
- If a particular therapeutic pathway is blocked by guardian/family then how do we enroll people into the plan you are trying to provide for an individual? (out of scope for this project)

8.1.7. Capacity Building

The broader issue of capacity building across the sector as it related to service providers was discussed within this consultation. The following list was established as representing priority areas and points that require action:

1. The need for sector workers to have access to specialist behavior support
2. Need to have experts reliably available, in the expectation of an increase in PSB being utilized.
3. The quantity of available experts must be adequate to reach sector-wide
4. Any access to expertise for providers needs to be affordable. For instance, it was suggested that this costs need to be absorbed by the ACT government. A possibility related to this is that the ACT government establish a behavioural specialist team, perhaps within an OSP, that is commissioned for a finite time period (e.g. for 3 years or similar). Needs to be affordable practice the game plan, e.g. where are needs over and above what is in the NDIS

plan there needs to be double up re staff for new staff to learn , mentoring from previously experienced staff.

5. There is a strong need for frontline workers and management teams to have capacity for "reflective practice"; for instance, multiple staff working with a person need to be able to reflect on their practice regularly within a team meeting and resolve and modify plans and practices.

8.2. Commentary from the mental health sector

The ACT has had several targeted quality improvement activities towards mental health in the context of seclusion and restraint, the revised Mental Health Act included.

Key concerns and suggestions around restrictive practices and this consultation were invited in May 2017 from representatives across the ACT mental health sector.

An initial area of concern raised within this consultation was the extent to which an external person (e.g. sitting outside of a mental health context) would understand the context of in-patient mental health. Specifically, this concern was related to existing issues where stakeholders felt that certain other agencies or sector employers struggled to understand specific contextual issues in mental health.

It was described within this consultation that currently there people who are using specialist mental health services can be either voluntary patients or involuntary patients, where the latter are subject to a current Mental Health Order. For this latter group, stakeholders report there is already a robust legislation-driven pathway, that establishes and tests clinical determination, with multiple steps, checks and balances in place, prior to a decision to use restrictive practices (such as restraint) is established.

As such, there was no stakeholder interest in an ACTOSP duplicating such powers.

That said, the question remains about how to safeguard the rights and freedoms of people not subject to Mental Health Orders, and how to support mental health service sector that, in addition to government-run specialist clinical services, comprises a range of non-government service agencies.

These non-government providers are not covered by the systems and processes which govern the use of restrictive practices in government mental health services, although the people with mental illness they work with may be subject to restrictive practices (including a requirement to take certain medications, attend for injections, restrictions on where the individual may live, etc.).

As such, stakeholders noted an ACTOSP could play a role in regard to supporting and regulating those services in the same way that the ACTOSP could do for disability providers.

Other comments included the importance of any ACTOSP being accessible to frontline workers, and that the ACTOSP was itself reviewed and evaluated and publicly reported, so sector workers would be able to view the reported improvements and advances over time in the context of restrictive practices.

Key findings from this consultation are overviewed below.

8.2.1. Regulatory function

Participants were not able to see how a Senior Practitioner could have a hands-on role in providing regulation against the use of restrictive practices within mental health contexts for the ACT. This was seen as impractical by many participants, suggesting that there were already systems and practices in place to oversee this. Instead, participants were supportive of the idea that an OSP could assist in promoting strategies to increase self-regulation. For example, by ensuring that any internal pathways of approval are regulated by clear frameworks and involve decision-making that has undergone several steps of review. It was agreed that clear signals form an OSP to support these kids of self-regulatory frameworks would be beneficial to the mental health sector. Examples were given of guidelines to set up internal panels or committees within organisation to oversee the use of restrictive practices and monitor them over time.

8.2.2. Monitoring and Investigative function

Participants were in favour of an OSP providing a monitoring function to oversee the use of restrictive practices across the sector. In particular, there was support for an OSP to have the mandate to disallow restrictive practices that are being used inappropriately. However, participants could not see how an OSP could provide valuable investigative functions to the mental health sector when other systems are in place. Instead, it was decided that it would be better for the OSP to have a close working relationship with other investigative bodies such as the ACT Official Visitors and the Human Rights Commission.

8.2.3. Capacity Building function

This was the category that participants were most supportive of being a main responsibility for a Senior Practitioner. Participants saw that a key issue for the ACT mental health sector is the challenge of how expert advice or best practice guidelines could cascade down to reach frontline workers. It was determined within this consultation that a priority area for any newly established ACTOSP or body should be in addressing this issue.

Participants expressed a desire for an office such as an OSP to act as a voice for consumers, perhaps by way of a Best Practice guide. Therefore it was considered imperative that any processes or pathways established in relation to an OSP include a mechanism whereby mental health consumer voices can be heard and incorporated into guidelines. One strategy around this could be to establish a reference or advisory group to work alongside the OSP in developing a Best Practice guide and such a group could include consumer representatives.

It was also suggested that an OSP could operate as a hub for all sectors across the ACT; therefore capacity building and awareness raising strategies would be its main focus instead of regulatory or investigative functions. Mental health sector participants could see value in this approach, especially as this model could see an OSP attending to the supply-oriented issues for the mental health sector and make the demand-oriented issues easier for frontline workers.

8.3. Commentary from staff working across the education sector

Consultations were held with a variety of stakeholders from the education sector across the ACT. Contributors included principals, classroom school teachers and staff engaged in senior education policy roles. There was also contribution from allied health staff based in educational settings.

It is acknowledged that the ACT Government has released a policy in April 2016 that provides some guidelines regarding the use of restrictive practices that can be applied within school settings.[6] This policy has been endorsed by the ACT Restrictive Practices Oversight Steering Group.

Participants reported that a key issue across the ACT education sector is the issue of best practice and restrictive practices. Participants asked *"How do we know what best practice is in this area- we don't have clear guidelines or explicit, staged plans for situations involving restrictive practices. For instance, what is in and what is out? Where is the threshold?"* Following this statement as a starting point, consultation discussion explored the main issues that participants could identify in relation to restrictive practices and then identified potential solutions to these issues.

The main findings from these consultations are detailed below.

8.3.1. The "Big Issues" regarding the use of restrictive practices across the ACT education sector:

- The issue of staff and sector accountability regarding restrictive practices. How can we establish guidelines and practices to make sector staff alert but not alarmed?
- We know we need to minimise the use of restrictive practices but how do we help staff to do this in everyday situations across the sector?
- How do we know what Best Practice is? We need an action plan that provides definitions, guidelines with the least amount of trauma for all parties concerned.
- What will be the interface between policy around restrictive practices in the ACT and the NDIS? Currently there are issues between the education sector and service providers- for instance, a provider might agree to or direct a certain practice but this may be inconsistent with the school recommendation. Providers are recommending practices that do not align with educational practice or are inconsistent with existing policy for schools. Where is the "universal" policy on this?
- Unfortunately, restrictive practices have become part of the normality and routine of everyday practice within schools. This highlights the need for a significant culture change to address this issue.
- Teachers need to be able to answer the question "what else, if not restrictive practices?" At the moment, participants felt that the average school teacher across the ACT probably could not do this confidently. Therefore, capacity building needs to be the priority for any office established or budget money.
- A strong understanding across sector workers of early intervention and prevention is missing. This is a priority area for where the sector needs to shift its focus. It is not enough to simply provide an examination of the use of restrictive practices across the sector. In addition there is a need for an in-depth analysis of the behaviours that lead up to this endpoint and examination of the practices from education sector workers in response to these behaviours.

[6] Principles for the reduction and elimination of restrictive practices in the ACT, ACT Government, 2016

- Any Best Practice Guidelines related to Restrictive Practices need engagement and commitment from across the Education Directorate with dedicated staff that can be contacted if necessary for advice and information.

8.3.2. Technical considerations

- Participants felt that an OSP or oversight body that provides external sign off is unlikely to be influential for education sector- sector workers are likely to only respond on updates or authority statements from the Directorate, via the Director of School Improvement (DSI) and the Student Engagement Unit.
- It has been shown previously that schools across the sector are slow to adapt to new processes or change of practice. Any new sector-wide changes need to be released in conjunction with change management principles, consultation and support.
- It was identified that there are certain risks if a system is established that sees schools doing an extra administrative process or feeling like "an OSP Big Brother is watching them." For instance, some contributors felt there could be a risk of reluctance from schools to take on students who have a support plan involving restrictive practices or reluctance from staff to follow official procedure regarding restrictive practices if the process is time-intensive or perceived as unduly burdensome.
- Participants stated that their preference regarding any official process for approvals of restrictive practices is to utilize the existing process that is already in place and has been agreed upon sector wide.
- Participants agreed that there needs to be an easy-to-access pathway for assistance and advice from an OSP if required.
- The Education Support Office within the Education Directorate was identified as the most appropriate central point for any information dissemination from an OSP and for channeling any advice or assistance from an OSP. Staff working in the education sector are already familiar with, and accustomed to receiving information from, this office.
- Therefore, overall, education sector representatives at this consultation would prefer that an OSP is established as a proactive capacity building role rather than a post hoc investigation and auditing role

Following this collation of key issues above, the topic of discussion centred upon ways in which the existing Education Office could be utilized as a conduit for information between sector workers and an OSP. The following ways were identified:

1. Gathering of data
2. Disseminating information
3. Taking the legal component of a process and translating it for relevant sector staff (e.g. especially for school principals)
4. Updating and dissemination of policies, with highlighted changes to make them clear for staff
5. Connecting staff directly to the OSP for any assistance required

It is recognized that the education setting is a distinct context and any analysis of the use of restrictive practices must pay regard to this distinction. For instance, many school settings operate on low staff numbers and are duty bound to consideration of other students and staff; the desires of

parents and guardians; and issues of safety. In addition, these considerations need to occur alongside evaluating the best interests of the child in question within any particular situation. For these reasons, participants provided the following feedback regarding the definition of restrictive practices for use across the ACT sector:

- Use a definition of restrictive practices that has sector-wide agreed upon terms, phrases and definitions and examples.
- Ensure that any definition of restrictive practices does not make reference to negative reinforcement or operant condition learning styles
- Provide concrete examples to establish sector-wide understanding that the issue of medication and restrictive practices is especially problematic and complex from an education perspective. The issues of staff safety and whole-school safety must be taken into consideration and it is known that the use of psychotropic medication for some school students can assist greatly with this. However this practice is restrictive. It is for these situations that any definitions or examples of restrictive practices in use across the ACT sector need to supply context-specific information to assist people in understanding the context of restrictive practices across various settings.

Following this discussion, it was clear that participants were fully supportive of a Best Practice guide being developed for the ACT around reducing and eliminating restrictive practices. This led to an exploration of what a Best Practice guide could contain and how it could be formatted in order to best serve the Act education sector. Contributors identified the following:

- Include readable definitions and statements regarding the use of restrictive practices that are relatable to educational settings;
- Include case examples to help the reader get a feel for situations and decision making
- Include a pathway for further assistance (such as to an OSP directly or via the Education Office)
- Include strategies for building parent understanding of restrictive practices to form strong partnerships between schools, providers and families.

Further to that, participants identified several priorities in relation to the issue of restrictive practices across the ACT education sector:

1. To have access to expert opinion and resources to assist in managing behaviours and assessing situations using restrictive practices
2. To have capacity building for staff that is accessible and workforce-appropriate
3. There is an ongoing need to work with families around restrictive practices in the school sector
4. Recognition that Catholic and independent schools will need to have their own pathway to an OSP as they sit separately the Education Directorate. If there is a RPAP panel set up then perhaps Catholic and Independent schools could share panel resources between districts

8.4. Commentary from stakeholders engaged in human rights

Consultations took place with representatives from the human rights sector in May 2017. Conversation was centred upon regulatory and legislative requirements in establishing an OSP and potential relationships and interfaces between an OSP and existing human rights-oriented processes.

It was discussed that if an ACTOSP is established as an approving permission- granting body (for instance if the model of an ACTOSP is designed as providing external sign off to permit the use of restrictive practices across the sector) then there could be a need to add to existing legislation.

It was recommended that if an OSP is established to stand alone as an independent body then it makes sense for it to be designed as an attachment or extension to an existing agency that is well-resourced. For example, contributors thought that an OSP could be attached to the existing Office of the Public Advocate or Human Rights Commission.

Exploration of these ideas also brought about the following points from contributors:

- If an OSP is located within the ACT government, this could result in issues with information-sharing. There are previous examples where this has been problematic. Information sharing can be a logistical issue and making this easier is necessary in establishing any new process.
- There are existing staff roles within the Human Rights Commission that carry powers of investigation
- There is an identifiable interface between an OSP with the existing ACT Official Visitors Scheme- the current investigation function could be carried out by Official Visitors as per current practice but this information could be reported directly to an ACTOSP.

The discussion that ensued within these consultations was oriented to three main areas in relation to reducing restrictive practices and establishment of an ACTOSP: 1) regulation of the use of restrictive practices, 2) Investigations related to the use of restrictive practices and 3) capacity building activities related to the use of restrictive practices.

The following summary outlines the main issues related to these three areas.

8.4.1. Regulation of the use of restrictive practices

- Contributors felt that it made sense for a system to be established that largely saw organisations creating internal processes for approving the use of restrictive practices, with access to support and expertise as required.
- If an ACTOSP could provide self-regulation guidelines to organisations then this might provide sector workers with the ability to better manage and approve the use of restrictive practices in-horse.
- However, caution was provided over how approval processes are set up internally within organisations. It is recommended that in-house approval systems are designed so that there is sufficient distance between oversight of approvals and frontline workers.

- For some uses of restrictive practices, there will be a need for a clinical decision. This would necessitate a reviewing role and not a pro-active investigative role. Participants felt that any newly designed OSP needs to have capacity to offer clinical expertise when needed.

8.4.2. Investigations related to the use of restrictive practices

- Participants supported the notion that an ACTOSP could have capacity to monitor and stop a restrictive practice if necessary. For many participants, this made sense if the OSP is to be established as a data owner (for instance, by way of a register) related to the use of restrictive practices across the ACT.
- If investigative functions were to be carried out by an existing Office or body (for instance, by staff within the Human Rights Commission or Office of the Public Advocate) then this would require some extra resourcing to that which is currently provided.
- Establishing an OSP office that has a key responsibility to report on restrictive practices across the sector allows for a model where the OSP can "go in to bat" for stakeholders, rather than take up the role of a critical investigative and sign off body.
- Sector-wide reporting of data would allow an OSP to inform stakeholders that "your threshold relating to the use of restrictive practices is too high"; that is, the senior practitioner would be in a position to offer a balanced voice to this issue across the sector.
- Whatever model of oversight is established, participants identified that there needs to be a clear pathway for a practitioner to refer an issue to an OSP and receive assistance and response to this.

8.4.3. Capacity Building related to the use of restrictive practices

- Participants identified a strong need for person-centred support/response to be used sector-wide to assist in supported decision making.
- It was readily agreed by participants that more education is required around Positive Behaviour Support. However, simply focusing on behaviour is sometimes not enough in considering the issue of restrictive practices. In certain cases participants felt that considering the environment is a key factor in understanding a person's behaviour and honouring their choices and desires. For example, if someone is continually showing challenging behaviours because they do not want to live in their current living situation, then applying Positive Behaviour Support techniques is not as beneficial as considering a change to their living situation.
- Participants felt that an ACTOSP needs to prioritise strategies and resources to offer support to families and people living in the community around the issues related to restrictive practices- that is, capacity building activities should not be focused solely on upskilling the workforce.

These discussions led to more detailed, technical discussions with staff engaged in senior roles related to human rights. This included the option of an ACTOSP having the ability to disallow a restrictive practice that is being used inappropriately It was emphasised that the disallowance would be directed to the specific situation or plan, and not to the provider or organisation more broadly. Similarly, any such disallowance would need to come with guidance to help build an alternative plan and strengthen practice.

8.5. Possible interfaces between an OSP and the ACT Official Visitors Scheme

Consultations with several representatives from the ACT Official Visitors Scheme were conducted. It was determined that existing practices and functions within these roles include:

1. Visiting various organisations, institutions, forensic centres, hospitals and other locations where individuals are receiving care;
2. Performing a pro-active monitoring and review role, including informal monitoring of the use of restrictive practices;
3. Conducting investigations based upon either a request via an individual or family member or based on an Official Visitor's observation. If it is related to an unapproved restrictive practice, the Official Visitor will speak to the service provider regarding the concern. If they are not satisfied they will talk to the relevant ACT government department or often they will take their concern directly to a relevant Minister.
4. If required, Official Visitors will then provide advocacy for individuals or assist in establishing support through an agency providing advocacy.

The role of the Official Visitors is provided with certain powers under the ACT Official Visitors Scheme ACT 2014. As part of their role, Official Visitors are able to appear in person at settings deemed as "visitable places" and request certain information. Further to this, they are able to question anything that they consider to be suspicious and speak in person with any staff member or consumer within the setting they are visiting. For example, the Official Visitor for mental health in the ACT is able to undertake the following:

1. Request to view the seclusion and restraint log for that setting
2. Enter the data in the Official Visitor records
3. Questions anything that is suspicious (e.g. repeated patterns for individuals, trends, and particular staff). The Official Visitor asks: "What was the purpose behind this? Why? What is next for this person?"
4. Provide a quarterly report to the Minister which includes: the frequency of seclusions/restraints noted; the length of seclusion; and any other information known

These functions as described above provide a clear picture as to the pivotal role being carried out by the Official Visitors across the ACT sector. It is easy to see how this exiting role could be utilized by an ACTOSP and there could be ways in which the Official Visitors could report directly to an OSP and assist with monitoring and investigative responsibilities.

Discussion with the Official Visitors who participated in consultations explored their viewpoints related to the establishment of an Office of the Senior Practitioner for the ACT. Contributors could readily see how the role of an Official Visitor could be integrated by an oversight body, particularly as the Official Visitors have built up excellent rapport and respect across the sector and are trusted by consumers. As a result, there is great reliance across the sector on the role performed by the Official Visitors. The following priorities and recommendations were made by Official Visitors in relation to establishing an ACTOSP:

1. A Best Practice guide is needed for the entire ACT sector around restrictive practices. As an example, at some ACT detention centres, the children are restricted by nature of being

there. However, there is concern from the Official Visitors that they are subjected to further restrictions (e.g. education, social). This could be seen as "Double Jeopardy" (twice the punishment) and often these restrictions are occurring owing to staff not being made aware of alternative practices to manage behaviours.

2. Common goals to be established between the interfaces of a system to oversee restrictive practices in the ACT. For example, clinicians, providers, Official Visitors, education workers and other sector workers all need to have common investment in a system that provides them with practice improvement.
3. An oversight body needs to promote accountability for the issue of restrictive practices and raise awareness around this
4. There is a need for regular and official training for the Official Visitors. Currently, training is of an informal nature.
5. It is important for any investigation to be done in a timely manner- otherwise significant issues become too distanced from the process of investigation. It is necessary for consumers reporting a concern to have an immediate course of action.

It can be seen from the findings above that the existing Official Visitors Scheme could be well-utilised by an ACTOSP. Additionally, this integration would be a low-cost approach in the first instance to investigative responsibilities for oversight of restrictive practices across the ACT sector.

8.6. Commentary from staff engaged with young people in out of home care

Viewpoints were heard from staff engaged in the care of young people who are in out of home care across the ACT sector. A summary of this consultation is provided below:

- The suggestion was put forward that any newly established Best Practice guidelines relating to the use of restrictive practices in the ACT should be written in accordance to the Children and Young People Act. This act is followed by the key peak organisations engaging with young people in out of home care across the ACT sector and it promotes making decisions in the best interest of the child and their rights.
- The need for any newly established ACT frameworks relating to restrictive practices to have a trauma-informed base. This need comes from sector staff engaged with young people in out of home care who have been at risk of being re-traumatised through some restrictive practices.
- There is a strong need to ensure that the ACT sector is continually improving their understanding of young people, with particular regard to the following factors:
    - The rights of young people
    - Techniques to empower young people who have increased vulnerability
    - Children's conception of safety, particularly young children.
- There is a need to raise the capacity of frontline workers who are in contact with young people in out of home care. In particular, a Best Practice guide could help to assist staff who are concerned about other staff members' responses to behaviours of concern from young people in out of home care.

- Amongst the cohorts that exist of young people in out of home care across the ACT sector, it is known that children living in residential care settings have increased vulnerability. It is recommended that any ACT oversight body focusing on restrictive practices pay close regard to this cohort.
- A clear recommendation that arose within this consultation was the need for any newly established oversight body to consult with stakeholders and engage consumers in conversations regarding the use of restrictive practices across the ACT.

8.7. Commentary from stakeholders engaged in aged care across the ACT sector

Representatives from key aged care organisations within the ACT sector provided input to this consultation. Several key issues came out of this contribution, particularly around the interface between ACTOSP Best Practice guidelines and the Commonwealth mandated quality indicators for aged care across Australia.[7] Some key points for consideration include:

- the relationship between use of physical and chemical restraint in aged care settings and its impact on quality of nutrition for elderly people;
- The negative impact of physical restraint on the wellbeing of elderly people in aged care settings;
- the times in which elderly people are most likely to be restrained. An ACTOSP could assist in analysis and reporting of this to establish local data trends;
- Acknowledgement that the quality indicators for aged care in Australia recommends that restraint-free environments are recommended practice. There needs to be a strategy from an ACTOSP to assist with meeting this quality goal.

8.8. Commentary from a former Senior Practitioner

A key consultation was held with Dr Jeffrey Chan in Phase 3, a former Senior Practitioner within the state of Victoria. Dr Chan held this position in its inaugural term and as such is able to provide critical and insightful reflection regarding the role of a senior practitioner, both past and present.

With Dr Chan's permission, a summary of this consultation is provided, including consideration of strategies, approaches that were implemented and "lessons learnt" from across the Victorian sector during his time as the Victorian Senior Practitioner.

8.8.1. Key enablers

1. The type and level of legislative powers provided to a senior practitioner are of critical importance. The Victorian Legislation allows for a Senior Practitioner to have sufficient powers of investigation and to request reviews "on reasonable grounds" of concern. These legislative arrangements can allow a Senior Practitioner the opportunity to approach an organisation to offer support and guidance at the same time as reviewing any concerns.
2. Shaping the senior practitioner role as a practice change strategy leader for overseeing restrictive practices is considered to be preferable to a compliance approach. This is because

[7] https://www.myagedcare.gov.au/quality-and-complaints/quality-indicators-in-aged-care/quality-indicator-use-of-physical-restraint, accessed online 22nd June 2017

a practice change strategy is about changing the mindset and mobilizing the sector towards the safe elimination of restrictive practices. Whereas a compliance approach might make it hard for a senior practitioner to obtain buy-in from organisations and is likely to result in a power-imbalance that can lead to decreased collaboration and synergy between an OSP and organisations.

3. It is preferable for a senior practitioner to have access to discretionary funding to invest in capacity building strategies that are tailored to meet situational requirements and needs, even if at first glance resources are being spent on activities that do not seem directly related to overseeing restrictive practices. Some examples provided by Dr Chan include providing funding for an organisation to purchase a pool table, which in turn saw a marked decrease in out-of-hours behaviours of concern within a residential care facility owing to residents now having a team activity of focus. A related example provided was resources allocated via the Victorian OSP Discretionary funds for an organisation to establish a market stall on weekends for individuals to sell handmade produce. This again provided individuals with a shared team goal and activity and saw a reduction in behaviours of concern across weekend timeframes.

8.8.2. Capacity Building activities

The senior practitioner is in a unique opportunity to fund targeted training programs. Examples from Dr Chan include:

- A program oriented towards consumers called “My Rights” self-advocacy program which evolved to “Keys to success”, a training program aimed to teach consumers about their rights.
- Guidance around Positive Behaviour Support training to improve the quality of support plans.
- Establishment of formal teaching groups and local Communities of Practice across the Victorian Sector
- The use of funding to support different types of grants. These include the “Dignity Grants” which is a learning & development strategy provided to service providers to develop creative alternatives to restrictive practices. These grants were promoted at a Show and tell style Research Day made open to sector workers and included poster presentations and award ceremonies. In addition, funds were used across the Victorian sector to provide $50 000 research grants where sector organisations could co-invest with partner organisations to collaborate on research projects related to the safe elimination of restrictive interventions.
- The use of funding to provide mindfulness training to staff working across the Victorian sector. Dr Chan detailed how effective this approach was as part of his efforts to offer different resources and tools to equip the OSP staff with. Staff were able to undergo training in Mindfulness techniques under the direction of a consultant Tibetan Monk who was commissioned by the Victorian OSP. Equipping staff with the tools and techniques to apply mindfulness and reflection “in-the-moment” to situations led to an increase in the ability of sector staff to manage behaviours of concern using positive based, person-centred care principles.

8.8.3. Use of Victorian Register

The Victorian OSP implemented an electronic population-based data system for recording, monitoring and analysing data related to the use of restrictive practices. It is the first and currently only population-based data system to record and monitor restrictive practices in disability services. This system is known as the Restrictive Interventions Database System (RIDS) and continues to be in use across the state. Dr Chan explained that he used core research principles in order to mine and analyse data using the RIDS system and implemented techniques to provide stakeholders with their own data and associated reports. In addition, the following methods were used when implementing the RIDS data system:

1. A Service Users Group was established, with regular meeting opportunities in local areas across the sector;
2. The RIDS system was built around simple user-friendly initiatives, including drop down boxes for built-in medical terminology options. Additionally, a subscription to the MIMS database was created so that up-to-date pharmacological information could be readily selected and updated if necessary;
3. A system was established within the RIDS system to escalate an alert to managers based on certain criteria related to the use of restrictive practices as recorded in the system;
4. The Victorian OSP staff created roadshows across the state where they promoted the safe elimination of restrictive practices and highlighted the way the RIDS system could record accurate and useful data that would be provided to organisations;
5. All Victorian Behaviour Support Plans (BSPs) are submitted electronically via the RIDS system. Using a validated tool called the Behaviour Support Plan Quality Evaluation II (BSP QEII) each plan is assessed based on 12 domains of quality. The RIDS data system provides a score out of 24 to indicate the quality of the submitted plan. During Dr Chan's time in the Victorian OSP, service providers received a training program called "Getting it right from the start" which is pitched at an Introductory Training program. Following this approach, Service Providers are then equipped to score and interpret their own BSP QEII score. This approach resulted in an effective system in which service providers are given the autonomy to self-regulate their own practice, with support from the OSP as needed. Using this approach, it would be possible for services to utilise BSP QEII scores as Key performance Indicators within organisations. Both Victoria and Queensland conduct research on this tool regarding factors that impact on the quality of behavior support plans.
6. The use of the RIDS system in Victoria has assisted in changing the way sector workers think about Positive Behavior Support. It is necessary to support staff to avoid being so prescriptive in their thinking that this results in Positive behavior Support principles being inadvertently used to implement restrictive practices. Rather, each and every support plan should be built around Positive Behaviour Support principles and the use of the BSP QEII evaluation tool, and its associated training, assists with this.
7. The use of the RIDS system in Victoria has allowed the Victorian OSP to critically look at the issue of restrictive practices across the sector, and reframe it using problem solving such as the capacity building techniques overviewed in this report and the use of the RIDS system. This approach has resulted in ownership of the issue being retained by the sector and not as simply a compliance model being requested by an oversight body.

9. Design elements for an ACTOSP

From consultations throughout this project, it is apparent that almost all consultation participants are supportive of the need for additional arrangements to address issues of restrictive practices, and that such arrangements include the establishment of an Office of the Senior Practitioner for the ACT. The exception was the ambivalence of an individual consultation participant who did not see the need for an ACTOSP because of the mandate of ACAT. However, this participant worked exclusively in clinical mental health services, and the participant's view was in that specific context. There is nothing in the analysis and recommendations in this section that is intended to cut across the mandate of ACAT.

Consultation participants anticipate an OSP for the ACT would be accountable for providing clinical leadership and oversight across the sector regarding the reduction, avoidance and elimination of restrictive practices. It is important to note that the role of an ACTOSP would encompass oversight of all persons living with increased vulnerability and/or who are at risk of being subjected to restrictive practice. These oversight responsibilities are therefore not limited to persons with disability but rather are inclusive of educational settings, mental health settings (both community and in-patient), hospitals, custodial and correctional institutions and aged care settings. The presence of an OSP would assist in bringing a strategic coordinated focus to managing down the use of restrictive practices with the goal of safe elimination of these practices over time.

Recommendation 1
That the ACT Government establish an Office of the Senior Practitioner ('ACTOSP') to provide leadership and oversight across all types of service operating in the ACT where restrictive practices may be operating, with the goal of avoiding, reducing and eliminating restrictive practices, in favour of positive alternatives that preserve the individual person's rights and freedoms.

Mindful of this general support, and following analysis of all data gathered across Phases 1, 2 and 3, we have identified several key elements that we consider to be the main functional considerations in relation to the establishment of an Office of the Senior Practitioner providing oversight of restrictive practices across the ACT sector. This section explores each of these elements, and includes a summary of what we consider to be the optimal approach, mindful of the views and preferences shared by consultation stakeholders.

The key elements are:

1. **Regulate**: the extent of the role of an ACTOSP in regulating the circumstances in which Restrictive Practices may be undertaken as part of a person's supports
2. **Adjudicate**: the extent of the role of an ACTOSP in investigating complaints and concerns, and determining if a practice should be discontinued and replaced by more positive alternatives

3. **Facilitate**: the extent of the role of an ACTOSP in leading and facilitating the growth in capacity of the ACT human services sector to reduce and eliminate Restrictive Practices in favour of positive alternatives

9.1. The role of an ACTOSP as a Regulator

Given the range of concerns prior to and during this consultation about the extent of use of restrictive practices in the ACT, there has been significant discussion within the consultation about what the OSP's role might be in the granting of permission for restrictive practices to be undertaken. It is important to note that the following content reflects the ethos of these discussions and reflects the issues and views put forward for consideration during consultations by stakeholders. While it is necessary to contemplate the ways in which an ACTOSP may act as a regulator, it is also critical to acknowledge that several processes are currently in operation across the ACT sector to provide a regulatory function against the use of restrictive practices. For instance, in the ACT mental health sector there are both firmly established legislation alongside a clear role performed by ACAT and other investigative bodies. Therefore, any regulatory function of the ACTOSP must be designed and implemented in a way that does not duplicate nor encroach on processes such as these which already provide an established regulatory function.

9.1.1. Reasons why it may not be helpful for the OSP to provide authorisation of restrictive practices

Early in the consultation there was interest in the potential of the OSP being the mandated gatekeeper for agencies seeking permission to undertake restrictive practices. However, as the consultation has progressed, support for this has diminished for reasons including the following:

- providing approvals for restrictive practices may compromise the OSP's independence in subsequently undertaking investigative work in relation to complaints or concerns about a mandated restrictive practice arrangement
- it is difficult to predict the volume of applications that would be made to the OSP for approval of restrictive practices. This could present significant resource implications for the OSP, and possibly some corresponding procedural delay
- through the ACT Civil and Administrative Tribunal there are existing provisions in relation to the consideration of treatment orders for people who are unwilling to have the proposed treatment, and this may include features of restrictive practices

9.1.2. The OSP as a developer and curator of restrictive practice authorisation standards

The main alternative is for the OSP to set and communicate standards of practice. This echoes aspects of arrangements in New South Wales and Victoria, and places the onus for decision-making with the service agency.

In this scenario, the OSP would develop and monitor practice guidelines/standards to be used by each human service agency operating in the ACT. These guidelines could include for example:

- a detailed set of considerations to properly test a service agency's thinking in relation to a person's supports, to help reduce the likelihood of the agency making the decision to include restrictive practices in the person's support arrangements

- a maximum timeframe (for example 13 weeks) for a support plan to run where it includes restrictive practices, by which time it must be reviewed
- a specified officer role within each service agency, to coordinate the decision-making process in relation to restrictive practices and to be accountable for associated reporting
- as is currently the case in [which jurisdiction(s)] a Restrictive Practices Authorisation Panel (RPAPs) at each service agency, comprising several perspectives (who earn a meeting fee if they are not employed by the agency), to provide input to the decision-making process. Where a service agency is small, there is the potential to coalesce with other agencies to access a common RPAP
- a clear expectation that any support plan including restrictive practices must include a specific and time-framed pathway for 'stepping down' the practices and replacing them with positive alternatives

Arguably, the approach here is comparable to that of the Australian Government's National Health and Medical Research Council and Australian Research Council, who set guidelines for ethical conduct in human research. The guidelines, the *National Statement on Ethical Conduct in Human Research*[8], set out clear standards for the formation and conduct of Health Research Ethics Committees, typically hosted by research service providers such as universities.

Such providers are not required to seek outside approval for proposed research but are expected to adhere to the national guidelines, which are detailed and specific.

New legislation could establish a requirement for agencies operating in the ACT to run the restrictive practice oversight standards, which then means the OSP could focus on curating those standards and offering advice and guidance to service providers on setting up and maintaining their arrangements.

Recommendation 2
That legislation is established to require all service agencies working with vulnerable people in the ACT, to run restrictive practice oversight standards, and that these standards be established and curated by the ACTOSP

9.1.3. The OSP as curator of RP data, providing analysis and reporting

Consistent throughout the phases of consultation has been the interest in better reporting of instances where restrictive practices are being undertaken. This can help reveal the incidence and prevalence of restrictive practices in the ACT, featuring which demographics and which service agencies.

This in turn can help signal which elements of the human services sector, and which agencies in particular, might be struggling to make progress and find alternatives to restrictive practice.

[8] National Statement on Ethical Conduct in Human Research 2007, (Updated May 2015). The National Health and Medical Research Council, the Australian Research Council and the Australian Vice-Chancellors' Committee. Commonwealth of Australia, Canberra. Accessed online 22/6/2017 at https://www.nhmrc.gov.au/guidelines-publications/e72

In thinking about how this interest may best be met, and by exploring the arrangements in other jurisdictions, the arrangement in Victoria stands out. Victoria's OSP arrangements include a database called the Restrictive Intervention Data System ('RIDS')[9], developed to record and report events of routine, PRN or emergency restrictive interventions such as chemical restraint, mechanical restraint or seclusion. Whenever a service agency resolves to run a support plan for a person that includes restrictive practices, that agency is required to log the information on RIDS.

There are a number of benefits associated with RIDS, that may be of interest in the ACT context, including:

- the opportunity to build a comprehensive dataset on the use of restrictive practices in the ACT, and to analyse and report this data
- the opportunity for service agencies to self-regulate and evolve practice, as a result of reports drawn from the dataset
- the capacity for service agencies to enter the data themselves, which can free up OSP resources to focus on data analysis, reporting and subsequent engagement with specific service agencies
- the capacity to evolve service agency approaches to support planning, including full consideration of alternatives to restrictive practices, through the way service agencies have to report their practice to the database.
- The capacity to set up automatic alerts in relation to plan timelines, plan quality, plan repetition, provider frequency, and other trends
- The opportunity to use the dataset contents as an informer for strategic capacity-building, and also as a measure of success of any such strategy.
- New legislation could establish a requirement for agencies operating in the ACT to run the restrictive practice oversight standards, which then means the OSP could focus on curating those standards and offering advice and guidance to service providers on setting up and maintaining their arrangements.

Provisions in legislation and/or regulations could establish a requirement for this data to be reported, and for agencies involved in restrictive practices to be required to supply relevant data.

The starting point for any good strategy begins with information to support informed choices. A constantly updated dataset of relevant information about restrictive practices is highly valuable in terms of its potential impact on awareness, self-regulation, and systemic capacity-building in favour of positive alternatives to restrictive practices.

While database development usually seems to signal significant development and maintenance costs, there is the opportunity to avoid much of these costs by seeking an arrangement with the Victorian government to access their database architecture. With appropriate firewalls and practices to protect privacy and ensure confidentiality, RIDS could serve the ACT well.

In addition, it is recommended that any new sector-wide database development strategy pays careful regard to existing data capture processes already operating across the ACT. For instance, in the mental health space there are already existing requirements that mandate provision of data

[9] Senior Practitioner Report, 2015-2016, Health and Human Services, Victorian Government

relating to the use of restrictive practices, such as under the Mental Health Act 2015 and the Mental Health (Secure Facilities) Act 2016. Any new arrangements must augment rather than duplicate these processes.

Recommendation 3
That the ACT Government establishes a data capture and reporting mechanism, to be curated by the ACTOSP, for the conduct of restrictive practices, and consider the economies and synergies that may be gained from negotiating access to an existing relevant database, in preference to an ACT design-and-build

9.2. The role of the ACTOSP as an adjudicator

Given the range of concerns prior to and during this consultation about the extent of use of restrictive practices in the ACT, there has been significant discussion within the consultation about what the OSP's role might be in the investigation of concerns and complaints in relation to restrictive practices.

9.2.1. The OSP as an investigator

During the consultation there has been significant interest in what might be done to investigate and eliminate unacceptable practices. This suggests that more can be done over and above current arrangements, but the question is whether an ACTOSP should play an active role as an investigator.

Currently there are other mandated roles in the ACT that carry investigative capacity. These include:

- ACT Official Visitors
- Human Rights Commission commissioners

It is likely that in the past these roles have investigated complaints that include concerns about restrictive practices. Therefore, the question is whether there is additional value to be gained from setting up an additional investigative capacity in relation to restrictive practices. Based on conversations particularly in phase 3 of this project, we suggest that it is not necessary to include in the ACTOSP the role of being the default investigator in relation to restrictive practices. Indeed this could create additional interface problems, whereby complainants or investigators would first need to resolve which channel a complaint should be passed through for investigation.

An alternative approach would be to invest in capacity-building of existing investigative arrangements, so that their investigative work is well informed (and regularly updated) in relation to the nature and manifestation of restrictive practices.

The ACTOSP could undertake this capacity building role with the investigative agencies, providing content leadership on key issues relating to the presence and consequence of restrictive practices.

This approach would help ensure there is no duplication of investigative effort, and no time lost in selecting which investigative channel to pursue.

This approach would mean that in the event the ACTOSP receives a complaint directly about an agency's practice, it would refer that complaint to the most relevant investigative agency.

Recommendation 4
That the role requirements of existing investigative arrangements operating in the ACT be updated to include detailed insights into the nature and manifestation of restrictive practices, and that the ACTOSP role include a provision to provide capacity-building support to those investigators

The above analysis and recommendation does not mean the ACTOSP would carry no direct investigative capacity. There are two particular circumstances where the ACTOSP can undertake a direct investigative role, and without duplicating the activities of other investigative agencies.

First, there could be a situation where a person (or their family or advocate) is unhappy about a service agency's decision to include a Restrictive Practice element in the person's support plan (this would be a separate situation to that whereby someone is unhappy with a plan that is currently in place and running).

In this situation, the complainant typically might call for a review of the decision and whether it is properly informed. In this type of situation, the ACTOSP (if they were undertaking the role as set out in the present document) would be best placed to undertake a review of the decision and associated documentation, since it is the ACTOSP that is developing and curating the best practice guidelines in relation to support planning and decisions, where RP might be considered.

As such, the senior practitioner or members of OSP staff might undertake an investigation via a paper review of the organisation's planning process and decision, as compared against the Best Practice guidelines.

Following this paper review, the ACTOSP might make one of two decisions:

1. Not intervene, but monitor the plan in action;
2. Instruct the agency not to implement the plan, and provide guidance on an alternative approach to support the person

A similar mandate is contemplated under the next heading, so please refer to recommendation 6 below.

The second circumstance where the ACTOSP might undertake a direct investigative role would be at a more systemic level within a service agency or agencies. In a similar way to the arrangements in Victoria, the ACTOSP could on 'reasonable grounds' undertake a review of a particular service agency's practices where there appears to be systemic issues in relation to supports and restrictive practices.

It seems unlikely that any existing mandated body in the ACT could readily undertake this work, because it requires deep insights and extended practice history in the field. In establishing an ACTOSP, such experience could be recruited in.

Recommendation 5
That the ACTOSP role include the mandate and capacity to undertake systemic investigation on reasonable grounds of the practices of any service agency operating in the ACT, with the primary goal of advancing that agency's capacity to use alternatives to restrictive practices

9.2.2. The OSP as an arbiter

While the above recommendations do not provide for the ACTOSP's direct role as an investigator of individual cases, bar the noted exceptions, there remains a question of its potential role in making a determination as a result of an investigation.

It appears clear that existing determination arrangements, for example through the ACT Civil and Administrative Tribunal, may not be sufficient to ensure the immediate discontinuation of unacceptable restrictive practice following its discovery. At least in part this will be because of the complexity of issues that may be involved in some situations, and which may require a particularly detailed and experienced eye.

We make the assumption that the ACTOSP is established to bring strong leadership in relation to alternatives to restrictive practices, it follows that the ACTOSP skill set will include deep experience in the complexity of circumstances may render a person vulnerable to restrictive practices.

Based on the above assumption, along with the assumption that comprehensive relevant information is gathered through investigations undertaken by investigative agencies in the ACT, the ACTOSP could be mandated to make a determination that a restrictive practice be discontinued.

This mandate could bring reassurance to government and community stakeholders concerned about restrictive practices, and provide a pathway to alternatives, particularly if the ACTOSP as the content and resource capacity to guide the service agency to a solution rather than just presenting that agency with the problem.

Victoria has included this provision within the OSP there, and the former Victorian Senior Practitioner has signalled this can work well, especially if an alternative course of action is also given to the service agency.

Recommendation 6
That the ACTOSP role includes the mandate and capacity to issue an order to a service agency to discontinue a restrictive practice

9.3. The role of the ACTOSP as a facilitator

Given the range of concerns prior to and during this consultation about the extent of use of restrictive practices in the ACT, there has been widespread acknowledgement within the consultation that the human services sector – including education, health, mental health, disability

support, older persons, etc. – is significantly underpowered in terms of capacity to craft and run support arrangements that include positive alternatives to restrictive practices.

These concerns include:

- the relatively low awareness across a range of stakeholder groups in the ACT about the nature and manifestation of restrictive practices
- the absence of a strategic approach to build capacity across the sector
- the limited availability of specialist assistance
- the costs of accessing such specialist assistance
- the need for consumer education, including support for families to (1) have increased awareness of restrictive practices and the issues associated with their use, and (2) discover and use alternatives to restrictive practices in the family home

9.3.1. The OSP as a sector capacity-building strategy leader

Given the above concerns, there is an opportunity for the ACTOSP to take a leadership role in raising awareness across all ACT demographics about the nature and manifestation of restrictive practices.

Based on anecdotal evidence provided to the consultation, this opportunity can be expected to contribute to a reduced use of restrictive practices as service agencies become more informed and consequently self-regulate. This is particularly so for arrangements where the person is being subject to arguably milder forms of restrictive practice that appear to be there mainly for the convenience of formal/informal supporters. It may also be so for arrangements where the restrictive practice has been installed because of a person's reaction to their choices not being honoured.

However, while emphasising the importance that service agencies should in any case be driven to find ways to safely remove restrictive practices, there will be situations where that process will be assisted by access to specialist expertise. Given what seems to be a systemically underpowered sector in relation to such expertise, there is a need for a highly intentional strategy to build capacity across human service agencies.

It's clear from the consultation that stakeholders anticipate the ACTOSP will bring thought leadership to the issue of restrictive practices and their alternatives. As such, it seems sensible that the ACTOSP role include the development and leadership of an ACT-wide strategy to both raise awareness of restrictive practices and their alternatives and to systematically build sector capacity in favour of those alternatives.

Also, given the issue of restrictive practices appears across a number of ACT government service portfolios, this option will provide a clear coordinated focus for capacity-building that will assist all relevant portfolios to make progress on this important issue.

Recommendation 7
That the ACTOSP role includes the mandate and capacity to develop and lead an ACT-wide strategy to raise awareness about restrictive practice and to build capacity in support of alternatives

9.3.2. The OSP as a direct capacity-builder

Over and above strategy leadership, there remains the question of how to marshal the availability of expertise to create resources (tools, workshops, etc.) that build capacity and build better support plans.

Based on consultation content, the following narrative below contemplates how an ACTOSP might assist the following themes:

- Availability of specialist expertise
- Development of best practice guidelines
- Building the availability of Supported Decision Making, and associated information about rights and choices
- Strengthening the quality of support plans
- Capacity for reflective practice

The narrative then concludes by contemplating:

- the merits of the ACTOSP taking a direct or indirect approach to capacity-building

Availability of specialist expertise

A consistent theme among consultation participants was the lack of availability of specialist expertise. Participants felt this would assist agencies deepen their capacity to use alternatives to restrictive practices in their support arrangements. While this mooted expertise typically translates to professionals with skills in applied behaviour analysis and positive behaviour support, it is important not to underestimate the importance of expertise in developing authentic person-centred plans, especially for people living with complex needs.

Consultation participants were clear that early investment in specialist expertise is needed.

Development of best-practice guidelines

The need for best-practice guidelines to be developed and disseminated sector-wide was a pervasive request throughout consultations. There is some existing evidence to support the components necessary for best practice with respect to avoiding restrictive practices. Webber et al (2011)[10] state that to effectively reduce, prevent and eliminate restraint and seclusion, organisations need to:

1. Provide staff with training and support,
2. Involve the use of advocacy for clients,
3. improve staff-client ratio
4. develop equipped response teams to crises
5. work within a state-level policy change that is adhered to.

As previously detailed in this report, positive behaviour support with person-centred planning at its core has been shown to be effective. This approach takes into account a person's 'Personal

[10] Webber, L., Richardson, B., Lambrick, F., & Fester, T. 2012. The impact of the quality of behaviour support plans on the use of restraint and seclusion in disability services, The impact of the quality of behaviour support plans on the use of restraint and seclusion in disability services, *International Journal of Positive Behavioural Support,* 2(2) 3–11.

Capital'[11], their own goals and builds on an assessment of the strengths and skills of that person. The approach honours the person's humanity, their intrinsic value, and their strengths and gifts, factors that are often overlooked in the rush to respond to what are seen as the person's more troubling circumstances.

There is good evidence that the following inter-related elements can be utilised, for example via best-practice guidelines, by service agencies to reduce and eliminate the use of restrictive practices:

1. Strong leadership for organisational change
2. Use of data to inform practice
3. Workforce development
4. Empowering staff with human rights values
5. Vigorous debriefing tools

The development of best-practice guidelines that cover the above and other themes, is again seen by consultation stakeholders to be an important area for early investment.

Building the availability of Supported Decision Making, and associated information about rights and choices

Consultation participants felt that there needs to be a process on any pathway established related to an OSP, that upholds whatever capacity a person has for participating in decisions about whether their support plan includes the use of restrictive practices. This is an important safeguard and is in keeping with the general sentiments of methodologies in Supported Decision Making.

Consultation participants also wanted to see a focus on information support for people who may be subject to restrictive practices, to assist in making choices and exercising rights.

The ACTOSP could provide leadership here by ensuring that accessible resources are available to people at risk of being subjected to restrictive practices, in relation to understanding and exercising their rights. For example, in Victoria the OSP commissioning capacity-building work from a local advocacy agency, involving the development of rights-based workshops and materials for people living with intellectual disability.

Strengthening the quality of support plans

The link between the quality of behaviour support plans and the use of restrictive practices has been outlined clearly in the literature, most recently by Webber, McVilly, Fester and Chan [12] with respect to the Australian context.

For instance, the implementation of the Behavior Support Plan-Quality Evaluation II (BSP-QEII), a standard criterion-referenced tool for measuring the quality of behaviour support plans has found that expertise in behaviour support is an important factor in overall quality of BSPs. Originally developed by Browning-Wright, Saren & Mayer (2003)[13] but revised by Webber et al (2011)[14] the BSP-QEII assesses 12 components of behaviour support planning, including:

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[11] Williams, R. (2013) Model of Citizenhood Support 2nd Ed. Julia Farr Association, Adelaide.

[12] Webber, L., McVilly, K., Fester, T., & Chan, J. (2011). Factors influencing the quality of behaviour support plans and the impact of quality of BSPs on the use of restrictive interventions in disability services in Australia. *International Journal of Positive Behavioural Support, 1(1),* 24-31.

[13] Browning-Wright,D, Saren, D and Mayer, GR (2003),*The behaviour support plan -quality evaluation guide* available from: www.pent.ca.gov (accessed 20 June 2017)

(1) defining the problem behaviour;
(2) specifying the predictors for each behaviour;
(3) analysing what is supporting the behaviour to occur;
(4) specifying environmental changes;
(5) hypothesizing functions that relate to the predictors of the behaviour;
(6) describing replacement or alternative behaviours that relate to the function of the behaviour;
(7) teaching strategies for alternative behaviour/s identified;
(8) specifying reinforcers for the alternative behaviour/s;
(9) outlining reactive strategies;
(10) specifying the goals and objectives that can be used to evaluate progress;
(11) details of team coordination; and
(12) details of communication strategies among staff.

The use of the BSP QEII instrument across the Victorian sector has shown that it is a valid instrument for services to self-measure the quality of support plans. Additionally, the 12 domains listed above act as factors that foster awareness and focus on person centred care and alternatives to restrictive interventions.

There is evidence to suggest that the following individual components of a Behaviour Support Plan (BSP) were the most difficult for direct support professionals in Victoria, even when assisted by the BSP QE II, provided to staff as a tool for writing support plans):

1. The factors supporting why the person uses the behaviour of concern
2. The environmental changes required to remove a person's need to use the behaviour of concern
3. The reactive strategies that would be used when the person used the behaviour of concern
4. Evidence of team coordination (for instance who would perform which role for the person)

Findings from analysis of BSPs reviewed, found a lack of information within the BSPs about the function of the behaviour, and about the replacement by alternative behaviours that could be taught.

The ACTOSP could directly lead the strengthening of support plans across the human service sector, especially for people living with complex needs who may be at increased risk of restrictive practices.

In additional to direct investment in planning skills, there are other ways the ACTOSP could stimulate the development of stronger support plans. For example, in Victoria the first Senior Practitioner operated a discretionary budget to award 'dignity grants' to agencies who needed a small quantity of additional funding of up to $2,000 (typically for one-off purchases) to run a plan that reduced the likelihood of restrictive practices being used.

Capacity for reflective practice

It is important to note that providers who contributed to this consultation highlighted the need for there to be adequate time for reflective practice, where support staff can step back and reflect on

[14] Webber, L., McVilly, K., Fester, T., & Chan, J. (2011). Factors influencing the quality of behaviour support plans and the impact of quality of BSPs on the use of restrictive interventions in disability services in Australia. *International Journal of Positive Behavioural Support, 1(1),* 24-31.

what is happening for the person being served, and what types of supports might work better. A number of providers have voiced the concern that the current NDIS pricing arrangements leave no room to undertake such practice and this is a concern, particularly for people who live with complex need and who may be more vulnerable to restrictive practices.

ACTOSP specialist personnel and best practice guidelines could help mitigate this issue, by providing materials that assist individual reflective practice in the moment, and collective reflective practice (including debriefing following an incident) when time is very short.

The merits of the ACTOSP taking a direct or indirect approach to capacity-building

If it is assumed the ACTOSP will bring content leadership to the ACT on the advancement of alternatives to restrictive practice, the above narrative suggests there are a range of capacity-building elements the ACTOSP could undertake that can bring benefits. It suggests there is strong merit in the ACT investing in sector-capacity-building which, arguably, could bring a greater dividend than investing solely in regulatory and reporting provisions.

There are two main ways the ACTOSP could lead this detailed capacity-building.

First, it could stimulate the market, by commissioning specialist practitioners to be available to the ACT sector, and/or by investing in providers of training and professional development to produce new specialist practitioners in the ACT.

Second, it could directly lead sector capacity-building, by recruiting and developing an in-house team of specialists. These in-house resources could provide on-demand specialist input to agencies, and develop a range of best practice resources, including capacity-building workshops.

The first option may carry merit because it is a systematic investment in sector capacity by stimulating supply of specialist skills. The main drawbacks might be that if the ACTOSP is commissioning specialist services, those services may come at a relatively high price given the current market scarcity. Also, the investment in the emergence of new specialist practitioners is a medium- to long-term strategy and is unlikely to provide relief in the shorter term.

The second option may carry merit because it gives the ACTOSP direct hands-on leadership in sector development; it will have more control over the substance and style of specialist input. Also, arguably in-house resources could be secured at a more competitive price compared to that charged by third party agencies in a scarce market.

The main drawback might be that the in-house option is dependent on the quality of appointment of the Senior Practitioner and the specialist team. If this is suboptimal, it will be harder to rectify in the shorter term, given that such appointments are likely to be for longer periods than third party contracts for service.

That said, the risk of sub-optimal appointments can be mitigated. For example, the first Senior Practitioner appointment in Victoria was made as a result of an exhaustive selection process, including the requirement for the candidates to produce 8 referees.

Given the low baseline of capacity in the ACT sector, as narrated by consultation participants, the optimal option would appear to be the development of in-house specialist resources, to provide specialist input and to develop best practice materials.

Recommendation 8
That the ACTOSP role include capacity to directly provide specialist input to agencies in relation to alternatives to behaviour support, and to develop other best practice materials that assist service agencies to build capacity

However optimal these in-house resources are, and as evidenced by some of the work undertaken by the Victoria OSP, there is also value in the ACTOSP having a discretionary budget to commission specific types of capacity-building or novel supports that can safely reduce and remove the use of restrictive practices.

Recommendation 9
That the ACTOSP role include budget capacity to fund initiatives that can help safely remove restrictive practices

10. The interface between the ACTOSP and national OSP arrangements

The analysis and recommendations set out in the previous section now need to be considered in relation to NDIS arrangements. This is because the NDIS Quality and Safeguarding Framework[15] contemplates the role of OSPs in the various jurisdictions, for example in the authorisation of restrictive practices.

The Framework also promotes the development of behaviour support plans that meet contemporary best practice as mandatory practice, alongside the rights for individuals to seek a review of their plan if they wish to do so.

The proposed options for an ACTOSP presented in this report are in keeping with these same recommendations related to best practice in development of behaviour support plans and access to support for individuals. Similarly, this report's recommendations include establishment of a data system for monitoring and reporting of restrictive practices across the ACT sector, and this is in line with similar recommendations proposed by the Department of Social Services to support nationwide accountability and reporting. In particular, the present report's proposed data system, monitoring and reporting strategy meets the factors identified within the Quality and Safeguarding Framework as reasons to support a higher-level sophisticated system for capturing and reporting on data related to restrictive practices. These reasons include a system that provides: the best protection of the rights of people with disability, maximum accountability, comprehensive data for identifying patterns and trends in the use of restrictive practices, the necessary information to support evidence-based practice, design to ensure reduced use of restrictive practices and design to enable assessment of what is working to support reduced use of restrictive practices.[16]

Because detailed NDIS safeguarding arrangements are yet to be confirmed and implemented at the time of writing this report, there are not enough signals for specific recommendations to be made relating to the interface between ACTOSP and NDIS.

Nevertheless, it is possible to contemplate the issues from the perspective of the proposed ACTOSP role, together with what is known about the NDIS intended approach, to make associated general recommendations.

Accordingly, this section looks at the key interface considerations between the ACTOSP and NDIS, based on the proposed three key functions of the ACTOSP outlined in the previous section, these being *Regulate*, *Adjudicate*, *Facilitate*.

10.1. Interface between ACTOSP and NDIS: Regulate

As per the narrative in section 9 of this report, there is no proposed role for the ACTOSP to 'approve' a practice, though separately under 'adjudicate' there is a proposed mandate to disallow a practice, subsequent to its approval by a particular service agency.

[15] NDIS Quality and Safeguarding Framework, 2016, Department of Social Services, Australian Government. Accessed online 15th June 2017

[16] NDIS Quality and Safeguarding Framework, 2016, Department of Social Services, Australian Government. Accessed online 15th June 2017

To the best of our knowledge at time of writing, the nationally appointed NDIS Senior Practitioner will not have an approval-granting role either. Rather any approval for the use of restrictive practices will remain the responsibility of local oversight bodies within each jurisdiction. This means that ACT-based NDIS participants would only have a restrictive practice provision included in their support arrangements if (a) their service agency deemed it necessary having first undertaken a process of consideration that is in keeping with best practice guidelines set by the ACTOSP, and (b) the NDIA approved the overall support plan and associated funding.

The main role of the ACTOSP in relation to 'Regulate' is to set and curate best practice guidelines in relation to the process for a service agency determining the extent of use of restrictive practices in a support plan, and to manage and report an associated database of such restrictive practices. Given the strong interest the NDIS has in similar matters through its service quality and safeguarding arrangements, it is important that there is a close working relationship between ACTOSP and relevant NDIS personnel, in relation to the development and curating of best practice guidelines, and the storage, analysis and reporting of restrictive practices data.

10.2. Interface between ACTOSP and NDIS: Adjudicate

As per the narrative in section 9 of this report, the main role of the ACTOSP in relation to 'Adjudicate' is to make a determination about a restrictive practice, in the main as a result of the investigation by another investigating agency.

Specifically, the relevant recommendation in section 9 includes a mandate for the ACTOSP to disallow a particular restrictive practice in relation to a particular individual and service. It is important to clarify that in this scenario, the ACTOSP would carry and exercise the mandate to disallow a particular practice even where the service agency is genuinely resource-constrained in terms of the alternatives. For example, a person's NDIS budget might be insufficient to genuinely accommodate alternatives to restrictive practices. This fact alone cannot excuse the use of such practices.

However, in disallowing a practice in such a situation, the ACTOSP's guidance to the service agency might need to be matched by a direct communication to the NDIA in relation to the recommended features of the person's support plan and what this might signal in terms of a reasonable adjustment to the individual support budget.

Meanwhile, the national Senior Practitioner role is expected to have powers of investigation for circumstances of concern for all NDIS participants. It follows that, in the event of a complaint being made relating to an NDIS funded service where there are restrictive practices being undertaken, the NDIS Senior Practitioner would directly undertake the investigation. It is assumed, therefore, that if the ACTOSP received a complaint relating to a restrictive practice in an NDIS-funded service, it would forward that complaint to the NDIS's national Senior Practitioner for action.

It is not yet clear if the NDIS Senior Practitioner would have the mandate to stop a restrictive practice as a result of their investigation, either directly as an order or indirectly through recommending the NDIA suspend support funding pending the development of an alternative to the restrictive practice.

However, if the ACTOSP role included the mandate to disallow a practice as per the recommendation in Section 9 of this report, the NDIS Senior Practitioner could make their investigation report available to the ACTOSP, in the same way that the ACTOSP might receive a report from the OVS or HRC. The ACTOSP could then consider whether to disallow the practice as a result of the investigation's findings.

For these reasons it is again important there is a close working relationship between ACTOSP and relevant NDIS personnel, in relation to the investigation and resolution of complaints relating to NDIS participant supports where restrictive practices are involved, and the cost implications of reasonable alternatives to restrictive practices in a person's support arrangements. It is important to ensure there are no gaps on mandate, so that unacceptable restrictive practices are stopped as soon as possible.

10.3. Interface between ACTOSP and NDIS: Facilitate

As per the narrative in section 9 of this report, the proposed role of the ACTOSP in relation to 'Facilitate' is to lead, deliver and commission capacity-building activities that help safely eliminate restrictive practices.

The NDIS will be similarly interested in agency/sector capacity-building in relation to alternatives to restrictive practices, particularly given that alternatives to restrictive practices are more likely to help deliver stronger outcomes for the person being supported, and therefore uphold the three key values intended to underpin the NDIS, namely control and choice, participation in community life and the economy, and the Scheme's financial sustainability.

Capacity-building endeavours bring costs to service agencies. Notwithstanding the ACTOSP resources contemplated in the Section 9 recommendations, there are still costs likely to fall to service agencies, in terms of the cost of staff time to attend such endeavours, plus the costs of backfilling where frontline staff are pulled from their normal shift in order to access the training.

These could be partially mitigated by the ACTOSP, for example by providing capacity-building input directly into service settings where staff are already located, and by providing relevant online content that gives service staff flexibility about when to access it. However these will not completely solve the problem.

The situation raises two issues relevant to the NDIS (and similarly to other funders). The first issue is the extent to which the total price offered by the funding agency to support the person is inclusive of the reasonable costs of frontline staff capacity-building, especially where the person is living with a degree of complexity that might give rise to the use of restrictive practices.

The second issue is the extent to which the NDIS leads and funds an investment strategy to build service sector capacity in relation to alternatives to restrictive practices for NDIS participants, and where the ACTOSP contributes to that strategy to the extent that is reasonable given the ACTOSP's overall resource and mandate.

Indeed, given the differing mandates and resource capacities of OSPs across Australia's jurisdictions, it seems sensible to assume the NDIS would carry this lead investment role in any such capacity-building strategy.

Also, capacity-building can be achieved in additional ways , for example through other provisions in the person's NDIS plan, for example funding for specific environmental changes or amenities that can help reduce the likelihood of situations where restrictive practices are then deemed necessary.

For these reasons it is again important there is a close working relationship between ACTOSP and relevant NDIS personnel, so that each plays their part to the fullest in building agency/sector capacity to find positive alternatives to restrictive practices.

10.4. Summary recommendation on the interface between ACTOSP and the NDIS (and any other significant funders of supports, for example in education, health, and aged care)

Based on the narrative earlier in this section, this report makes the following recommendation.

Recommendation 10

That the ACT Government, or the ACTOSP as soon as possible following its establishment, resolves a clear and documented working relationship with the NDIS in respect of at least the following:

1) the establishing and curating of best practice guidelines relating to the development of support plans that minimise/avoid use of restrictive practices,

2) the storage, analysis and reporting of restrictive practices data

3) the receipt of complaints about restrictive practices in NDIS-funded services

4) the initiation and conduct of specific investigations and/or systemic reviews of agencies where restrictive practices are a concern

5) the disallowance of unacceptable restrictive practices following such investigations

6) the initiation of a review of the costs of an individual support package, to ensure it includes the reasonable costs of delivering alternatives to restrictive practices

7) the leadership, strategy and funding of capacity-building activities to service agencies to adequately install reasonable alternatives to restrictive practices.

This recommendation would similarly apply to other human service funders relevant to the ACT, for example in education, aged care, etc.

11. Governance

The consultation included consideration of where an ACTOSP might be located organisationally.

Because the ACT is a small jurisdiction with limits on resources, there was not strong support for establishing the ACTOSP as a standalone organisational entity.

Instead, the work of the ACTOSP could be hosted by an existing entity within the ACT, especially where there might be synergies without any conflicts of interest.

Because various ACT government directorates are involved in service delivery to at least some extent, there was concern that hosting the ACTOSP within a government directorate might present a conflict of interest.

Generally, there was more support for the ACTOSP being hosted by an existing body not involved in direct service provision or service commissioning. This suggests that bodies such as the Human Rights Commission might suit, given that the ACTOSP goal might be seen as leading the safe removal of restrictive practices, and the associated implications for upholding a person's rights, freedom of choice and freedom of movement.

Recommendation 11
That the ACT Government consider locating the ACTOSP within an existing authority operating in the ACT and that is independent of service provision/commissioning

Given the range of interest within government and community for the role, as evidenced by the range of perspectives encountered during the consultation, there may be merit in the ACT government establishing an advisory group to provide advice and support to the ACTOSP in relation to developing and implementing the various role elements described in Section 9. This group could also bring elements of co-design to the role, to assist strategic refinements and continuous quality improvement in the work of the ACTOSP.

It is important that any such group's membership reflect a range of stakeholder perspectives.

Recommendation 12
That the ACT Government considers establishing a multi-stakeholder advisory group to provide advice and support to the ACTOSP.

12. Summary of proposed pathway, and means of influence

To help illustrate key elements of the narrative and recommendations in this report, this section provides a summary of the pathway elements for 'regulate', 'adjudicate' and 'facilitate'.

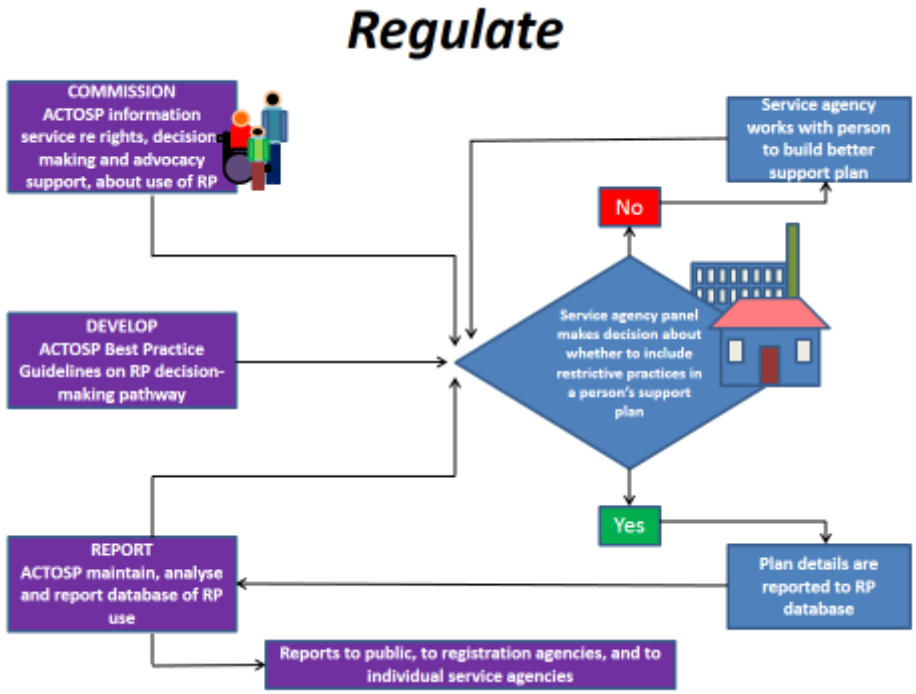
12.1. OSP Role 1: Regulate

Regulate refers to the role of the OSP in setting the coordinates for how restrictive practices in the ACT are permitted, reported and analysed.

In this respect, this report proposes the ACTOSP undertakes three main roles:

- ***Develop***: Develop, distribute and monitor Best Practice guidelines for agencies working in the ACT with vulnerable persons (this includes children, people living with disability, people living with mental illness or other chronic health conditions, and older people)
- ***Commission***: Commission and monitor availability of information about rights, decision-making, and complaints, in relation to restrictive practices and their alternatives, for use by vulnerable persons and their advocates
- ***Report***: Maintain, analyse, and report data on use of restrictive practices in the ACT

The following graphic illustrates the ACTOSP's role in the proposed *Regulate* pathway.



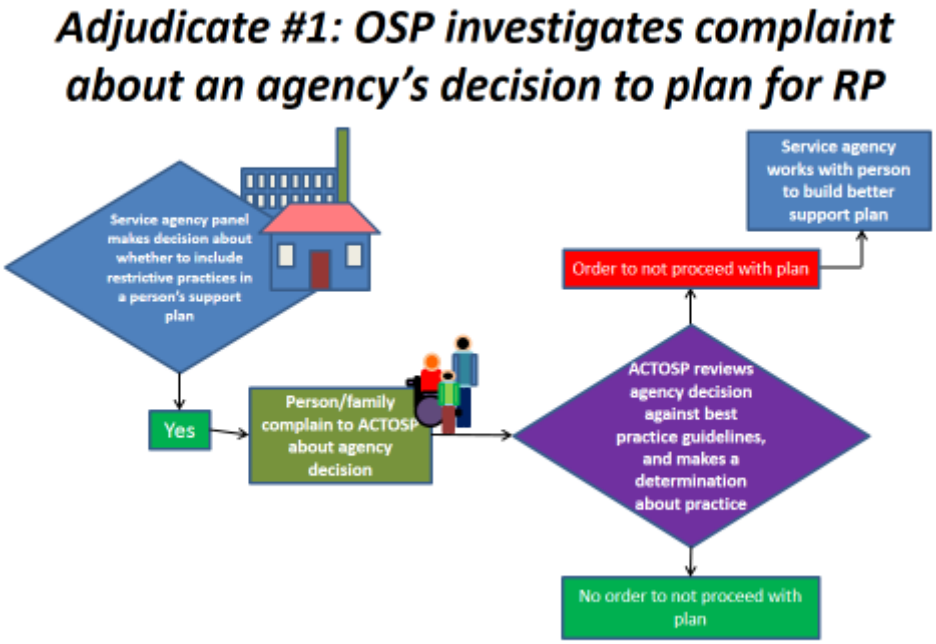
12.2. OSP Role 2: Adjudicate

Adjudicate refers to the role of the OSP in actions taken in response to concerns about restrictive practices.

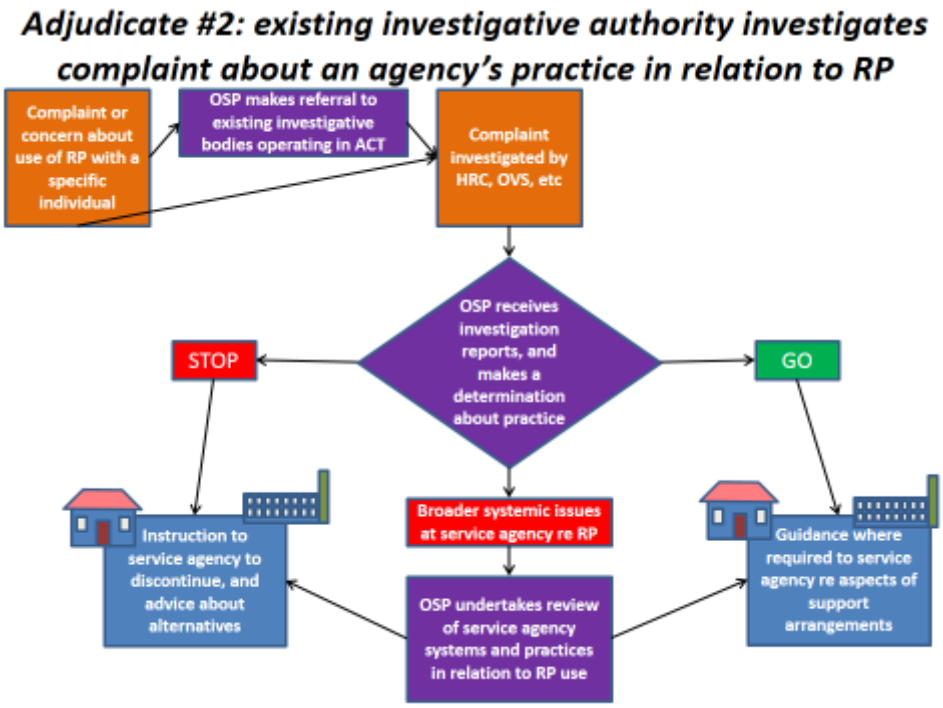
In this respect, this report proposes the ACTOSP undertakes four main roles:

- ***Direct investigation***: desktop review in response to person/family concern about agency decision to put RP in a support plan
- ***Refer for investigation*** : Make referral to existing investigative bodies in ACT, in relation to practice concerns about specific service provider practice
- ***Receive report and Determine***: Receive investigation reports (either from own desktop review or from existing investigative bodies) and make a determination about practice, particularly the power to instruct a service provider to discontinue (or not install) a restrictive practice
- ***Systemic review***: Undertake on reasonable grounds a systemic review of a service agency's systems and practices in relation to the incidence and prevalence of restrictive practices at that agency

The following graphic illustrates the ACTOSP's role in that part of the proposed *Adjudicate* pathway relating to a direct investigation in response to a complaint about a service agency's decision to include restrictive practice in a person's support arrangements.



The following graphic illustrates the ACTOSP's role in the remaining part of the proposed *Adjudicate* pathway.



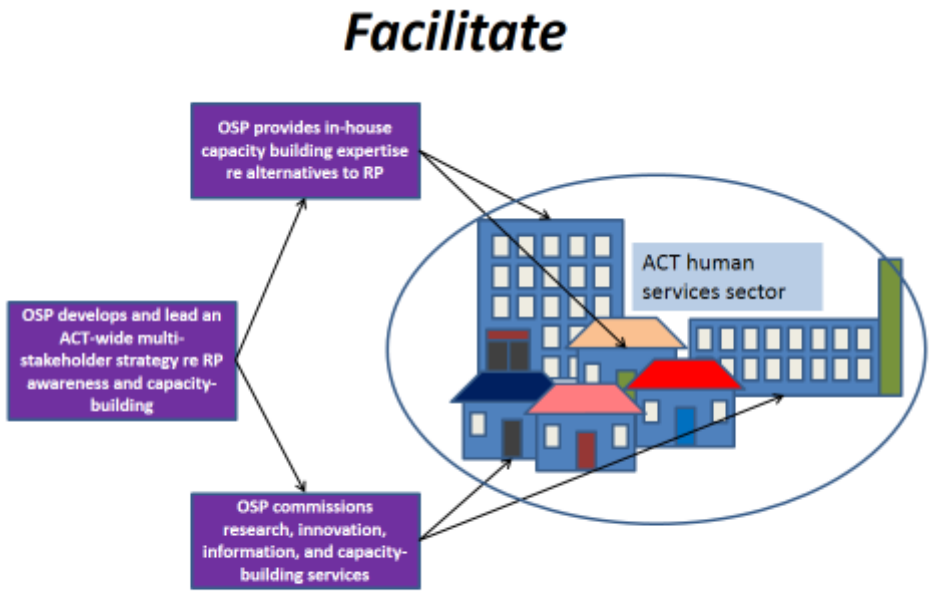
12.3. OSP Role 2: Facilitate

Facilitate refers to the role of the OSP in actions taken in assisting the ACT human services sector grow its awareness about restrictive practices and its capacity to use alternatives.

In this respect, this report proposes the ACTOSP undertakes three main roles:

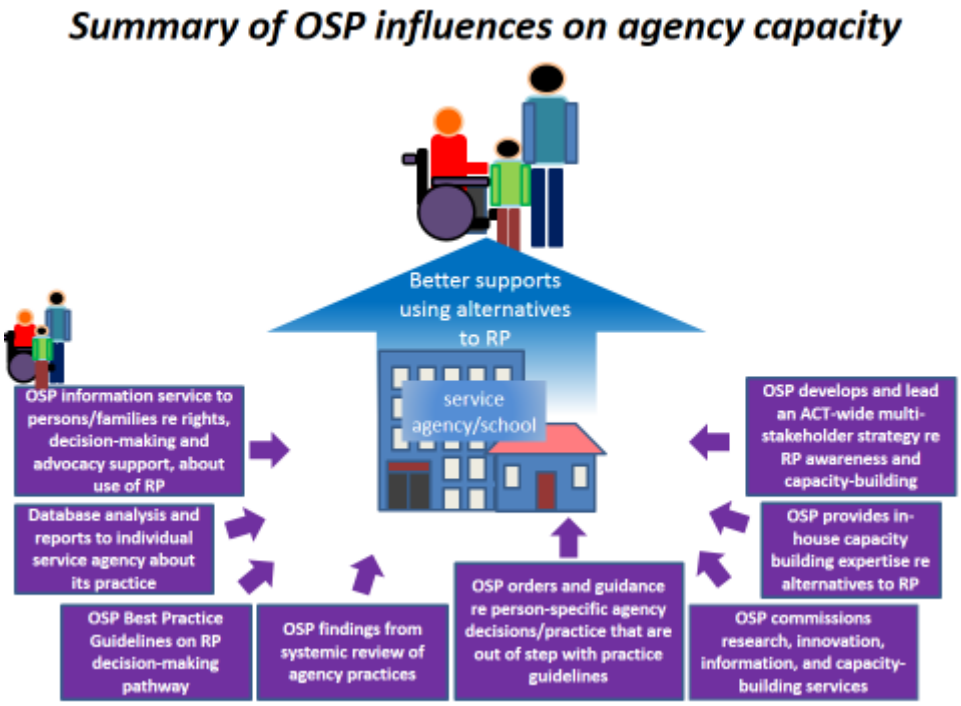
- ***Lead***: Develop and lead an ACT-wide multi-stakeholder strategy to raise awareness and build service agency capacity (and family capacity) to minimise and eliminate use of restrictive practices, in favour of alternatives
- ***Train***: Provide in-house capacity-building expertise to the sector in relation to positive behaviour supports and other techniques such as authentic person-centred planning
- ***Commission***: Commission research, innovation, information and capacity-building services, that contribute to sector capacity to use alternatives to restrictive practices

The following graphic illustrates the ACTOSP's role in the proposed *Facilitate* pathway.



12.4. Summary of the proposed means of ACTOSP influence on the reduction and elimination of restrictive practices in favour of positive alternatives

The following graphic summarises that range of proposed ways that the ACTOSP can provide influence on the reduction and elimination of restrictive practices in the ACT.



13. Implementation

The recommendations that appear in this report have been developed with the understanding that the ACT government is working to a finite budget and therefore not all possibilities for reducing and eliminating restrictive practices are within equal operational reach, in terms of resource and timeframe.

Accordingly, the recommendations put forward in this report are intended to be a fair synthesis of the views of the ACT community as gathered through this consultation, tempered by a due regard for the pragmatics of the ACT Government's likely resource limits.

Additionally, these recommendations are formed in the knowledge that there are some parts of the ACT sector that are less regulated than others, with differing level s of existing regulatory functions across the sector. Therefore, the recommendations and suggested points of implementation acknowledge these differences in regulation by way of consideration of interfaces. For instance, the health and mental health sector is heavily regulated with existing legislative, policy and clinical interfaces that would need to be carefully scoped and mapped out by ACTOSP staff during an implementation stage. Similarly, staff members providing services to children in out of home care are mandated to fulfil the regulatory requirements as dictated by the Children and Young People Act and any interfaces that exist between this function and that of an ACTOSP would need to be equally scoped.

In framing the recommendations, the report writers have also had regard for the importance of establishing a balance of investment between guidance and capacity-building elements (the 'carrot') and investigative and disallowance elements ('the stick'). This was emphasised by a number of key consultation participants, including Dr Jeffrey Chan. It is the report writers' view that the balance of investment should be in favour of the 'carrot', especially in terms of deepening service agencies' intrinsic connection with, and capacity to uphold, the values underpinning alternatives to restrictive practices.

Recommendation 13
That any staged implementation of ACTOSP ensures a robust investment in capacity-building activities relative to compliance activities

This section suggests a summary implementation plan for development of an ACTOSP, crafted to reflect the recommendations and the synthesis of the stakeholder views and issues on which those recommendations are based.

The table below is a *sample* summary implementation plan. It does not assume a specific date when the implementation would commence, and so cannot give specific dates for each milestone. Therefore the timeline is based on a time-count from 'day 1', when the proposal is given formal approval to proceed.

Note that a key milestone is the appointment of the ACT Senior Practitioner. To assist the thinking about the post holder characteristics, we have included as brief overview in Appendix 1, drawn from the contributions from key consultation participants.

Table 2: Sample implementation plan for establishing and operationalising an ACTOSP

Description of milestone	What is involved	Suggested time-count from Day 1
Development of ACT specific legislation relating to the role of a Senior practitioner	Formulation of legislation that equips an ACT senior practitioner role with the necessary powers and mandate to meet the needs and functions of this role.	3-12 months, dependent on legislation being passed (should be undertaken concurrently with below activities)
Recruitment of a senior practitioner	Preparation of job and person description, advertising, selection, take up of multiple references, and timeframe for appointee to vacate current position	3-6 months
Initial collation of relevant information	*(can begin momentum while SP selection process is running)* Initial research and collation of source materials relevant to policy, best practice, and agency interfaces.	3 months
Negotiation with relevant jurisdictions re access to functional database	*(can begin momentum while SP selection process is running)* Scoping of options for access to existing database capacity, including resolving service agreements	3-7 months
Establish proactive approach to stakeholder communications	Develop and implement a stakeholder communications plan, including regular bulletins/newsletters/communique from ACTOSP that are disseminated sector wide and include updates, tips, strategies, evidence-based research findings and other useful information related to minimising restrictive practices	3-7 months
Populating the database, and analysis and reporting the use of restrictive practices across the ACT sector	Develop and implement protocols and associated training materials for service providers to enter data directly and generate own reports on their practice. This includes use of BSP-QEII.	12-18 months

Description of milestone	What is involved	Suggested time-count from Day 1
	Establish availability of database auto-alerts	
Recruitment of staff members to work within an ACTOSP office	As above, and includes people with expertise in behaviour support and analysis and staff with specialised skills in data curating and analysis.	4-9 months (rate limiter will be the arrival of SP, who should play key role in selection of team)
Development of Best Practice guidelines, policies and resources for dissemination sector-wide	Ascertain by way of mapping the internal processes currently occur across the ACT sector regarding the use of restrictive practices	9-12 months (rate limiter will be the arrival of SP, who should play key role in development)
Scoping of existing regulatory functions related to the use of restrictive practices currently in operation across the ACT sector	Ascertain by way of mapping the current regulatory functions that occur sector-wide, such as regulation with existing legislative, policy and clinical interfaces in order to neither encroach nor duplicate current processes	6-9 months (rate limiter will be the arrival of SP, who should play key role in development)
Development of key interfaces with other relevant bodies in ACT, and NDIS	Resolve and document role relationships between all agencies (e.g. OVS, HRC, NDIS) likely to be involved in regulation and/or investigation of services where there are restrictive practices, and the capacity-building for alternatives	6-9 months (rate limiter will be the arrival of SP, who should play key role in development)
Development of an ACTOSP hosted website that allows users to access context-specific resources, strategies and information relating to the safe elimination of restrictive practices and the implementation of alternative strategies.	Commissioning of website architecture, and development of content This could also include a mechanism for users to have access to standardised instruments such as the BSPQEII in which they could be offered self-directed training related to its use and examples of "gold standard" support plans across a variety of settings and circumstances. Website could also have a section aimed towards consumers (inclusive of family members) to offer readable and accessible information relating to restrictive	9-12 months (rate limiter will be the arrival of SP, who should play key role in development)

Description of milestone	What is involved	Suggested time-count from Day 1
	practices and strategies for exploring alternative approaches in supporting a person with challenging behaviour.	
Development of a capacity building program for the ACT sector	Activities will include consultation with multiple stakeholders to map existing capacity and priorities, commissioning of content experts, and development of program curriculum, and resource sources	12-18 months

14. Appendix 1: Considerations for the qualifications, skills and characteristics required for the role of Senior Practitioner

The characteristics of a person or persons who carry out the role of a senior practitioner were discussed at length within Phases 2 & 3 of this consultation. One person stated: *"You need someone who's prepared to make a very rigid decisions as to if something should or should not be allowed".* Other participants named various qualifications, backgrounds or experience that they felt were necessary for a person to fully execute this role. Examples included human rights specialist, psychologist, lawyer, trained healthcare provider or social services background.

The overall characteristics and factors required for consideration were:

- to be skilled at understanding the circumstances of people subjected to restrictive practices
- to be established in collaboration with other services and policy makers
- to require mandatory reporting
- to offer outreach services such as spot audits, training and capacity building, counselling of staff, case by case assessment or advice.
- to have an office or panel of staff with different skill sets. For instance, there could be an Expert Committee established. This could be a multidisciplinary mix of people, including a teacher. This committee could act a sign off committee for the key work that is undertaken by the Office of the Senior Practitioner.

Consultation with Dr Jeffrey Chan and other highly-regarded clinicians skilled in behaviour support provoked additional reflection on the possible qualification, skill set and qualities of an ideal ACT based Senior Practitioner:

- To be experienced as a high-level behaviour support clinician
- To be experienced in research and understanding evidence-based research and practice
- To be experienced in practice change and leadership related to this
- Demonstrated ability to problem solve, innovate and implement strategic change
- To be experienced in, or otherwise have good insights to, a number of different service sectors, including disability, mental health, education, aged care, etc