Victorian Senior Practitioner Seminar

5 December 2024

VICTORIA State Government | Families, Fairness and Housing

We acknowledge the Traditional Owners of Country throughout Victoria and pay respects to their Elders past and present.

We acknowledge that Aboriginal self-determination is a human right and recognise the hard work of many generations of Aboriginal people.

Social
Services
Regulator

Jonathan Kaplan

Social Services Regulator

December 2024

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Acknowledgement of Traditional Owners

I would like to begin by acknowledging the Traditional Owners of the lands on which we are meeting today and pay my respects to Elders past and present, as well as to all the Aboriginal and Torres Strait Islander people who are joining us today.

The new scheme

About the Social Services Regulator

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Snapshot of the new Social Services Regulatory scheme

Scheme commencement – 1 July 2024

A single **regulator** that is **independent** from the Department of Families, Fairness and Housing

Registration

Social Services Standards and Child Safe Standards

Worker and carer exclusion scheme

A comprehensive regulatory toolkit and fit-for purpose **incident reporting** to effectively support **compliance and enforcement**

Information sharing and other provisions to reduce regulatory burden

Social Services Regulator

What has changed?

Previously:

- many service providers were subject to **overlapping** regulatory schemes
- **fragmented** social services system **creating barriers** to effective risk management by government
- some services were **not formally regulated,** and instead had safety standards embedded in funding contracts

… From 1 July:

✓ A single, **independent** regulator monitoring and enforcing compliance with the SSR Act and Regulations

✓ **Promoting and supporting** delivery of safe and effective social services

✓ Putting **service user safety** at the centre of social service delivery

Social services covered by the new scheme

Services in scope of the Social Services Regulator

- **Children, youth and family services,** including **child protection**
- **Disability services***
- **Supported residential services**
- **Homelessness support services**
- **Family violence support services**
- **Sexual assault support services**
- Out-of-home care and secure welfare services

* provided or funded by the Department of Families, Fairness and Housing (DFFH), or funded by Transport Accident Commission or WorkSafe)

The focus of our work

- **Education and engagement** across the sector
- Managing **registrations**
- **Regulating** six Social Service Standards and the Child Safe Standards

- Monitoring and responding to **incident notifications**
- Acting to ensure the safety of social service users
- Responding to breaches of legislation

✓ Replaces the Human Services Regulator

✓ Working with co-regulators

✓ Making decisions independently (we are not directed by the Minister)

Our co-regulators include: Commission for Children and Young People, Victorian Disability Worker Commission, NDIS Commission

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Requirements for in-scope providers

1 In-scope social service providers must **register**

2 Providers must meet six Social Services **Standards** when providing services they are registered for

3 Providers must **notify** the Regulator about certain things (e.g. some incidents and appointments)

Some disability services are excluded from the scheme by the Regulations, including:

- ✓ A regulated disability service defined under the *Disability Act 2006*, including disability advocacy
- ✓ A service provided as a NDIS provider to a NDIS participant

Social Services Regulator

Compliance requirements

Meeting the Social Service Standards

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The six Social Service Standards may look familiar

Standard 1: Safe service delivery

Standard 2: Service user agency & dignity

Standard 3: Safe service environment

Standard 4: Feedback and complaints

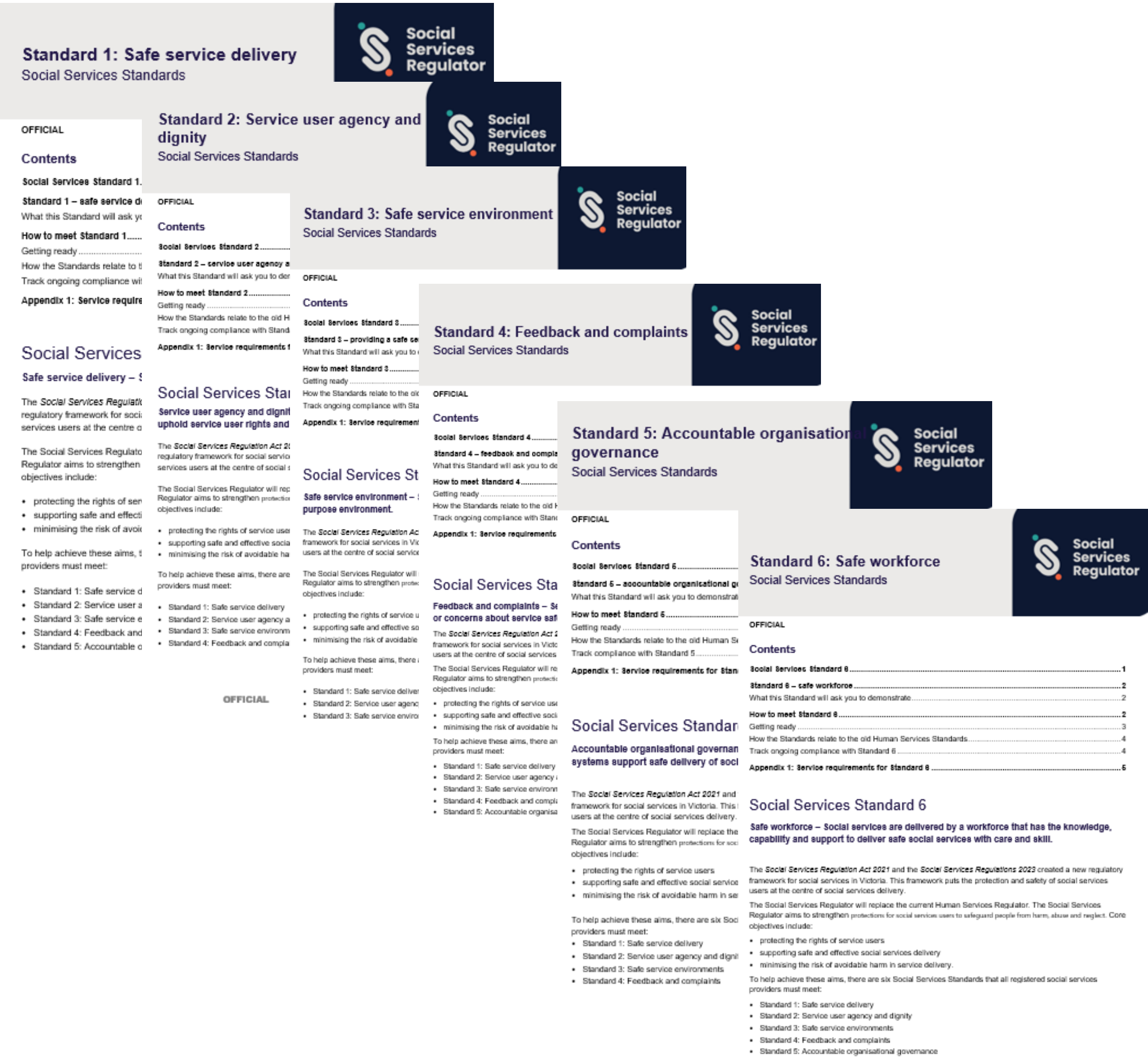
Standard 5: Accountable organisational governance

Standard 6: Safe workforce

https://www.vic.gov.au/social-services-regulator-social-services-standards

Summary: how to meet a Standard

- Each Standard aims to meet several **outcomes**
- Service providers need to meet ALL **service requirements** in a Standard to meet the Standard
- There are **multiple service requirements** in every Standard
- Build in practices and procedures to demonstrate **ongoing compliance**



Standard 1: Safe service delivery
Social Services Standards

Standard 2: Service user agency and dignity
Social Services Standards

Standard 3: Safe service environment
Social Services Standards

Standard 4: Feedback and complaints
Social Services Standards

Standard 5: Accountable organisation
governance
Social Services Standards

Standard 6: Safe workforce
Social Services Standards

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Contents

Social Services Standard 6

Safe workforce – Social services are delivered by a workforce that has the knowledge, capability and support to deliver safe social services with care and skill.

The *Social Services Regulation Act 2021* and the *Social Services Regulations 2023* created a new regulatory framework for social services in Victoria. This framework puts the protection and safety of social services users at the centre of social services delivery.

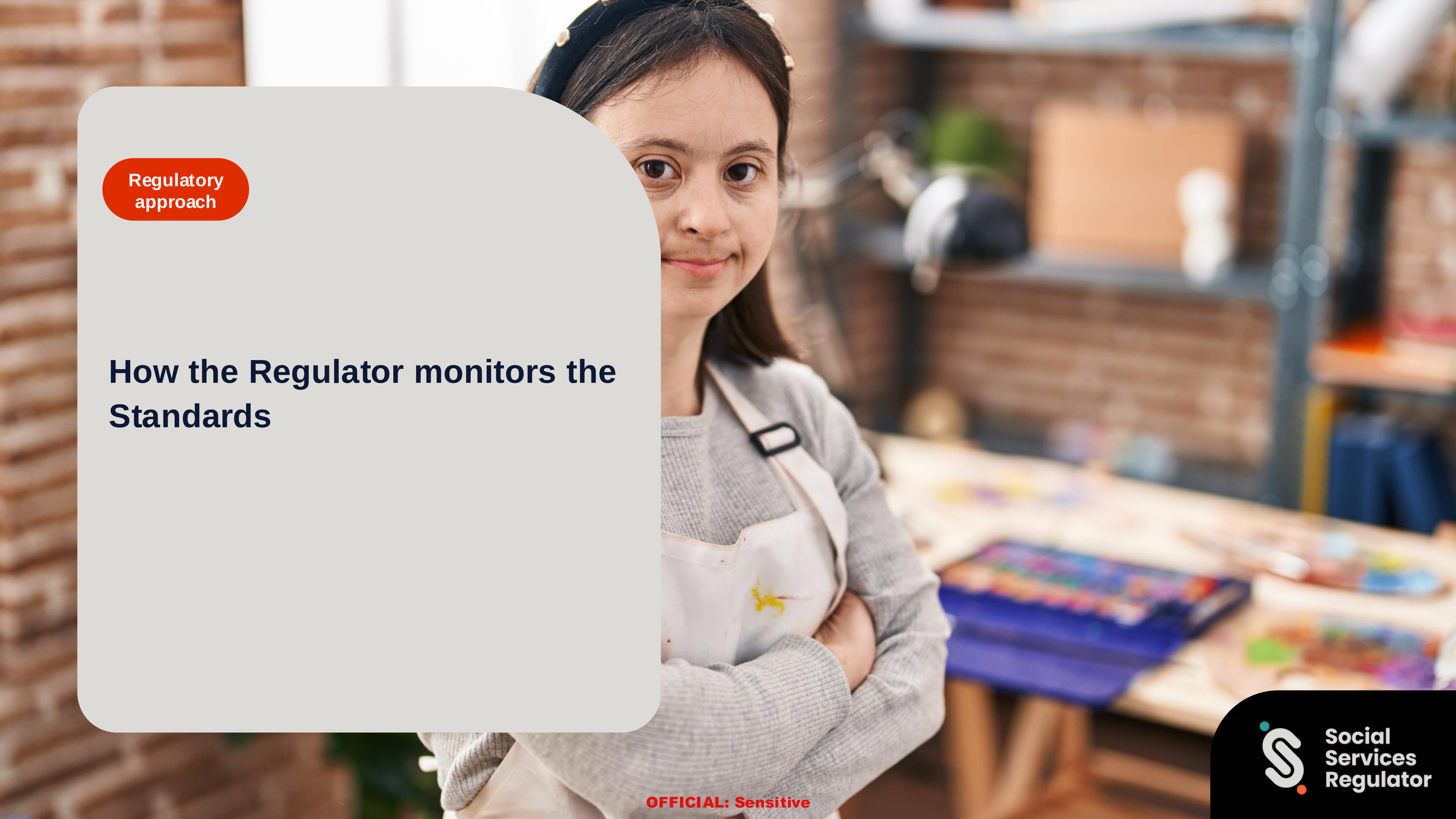
The Social Services Regulator will replace the current Human Services Regulator. The Social Services Regulator aims to strengthen protections for social services users to safeguard people from harm, abuse and neglect. Core objectives include:

- protecting the rights of service users
- supporting safe and effective social services delivery
- minimising the risk of avoidable harm in service delivery.

To help achieve these aims, there are six Social Services Standards that all registered social services providers must meet:

- Standard 1: Safe service delivery
- Standard 2: Service user agency and dignity
- Standard 3: Safe service environments
- Standard 4: Feedback and complaints
- Standard 5: Accountable organisational governance

Download at: https://www.vic.gov.au/social-services-regulator-social-services-standards



Regulatory approach

How the Regulator monitors the Standards

The Regulator’s approach to monitoring the Standards

While our initial focus is on guidance and education:

Where the scheme introduces new requirements, we recognise these providers may need more support to get things right

Over time, we expect service providers to comprehensively implement the new Standards

We will not hesitate to act to protect service users from harm, abuse and neglect

Our focus is:

- ✓ giving primary consideration to the **protection of service users** when carrying out our functions
- ✓ **minimising** risks of avoidable harm in social services delivery
- ✓ **promoting and supporting** the delivery of safe, effective social services, and continuous improvement

Social Services Regulator

Meeting the Child Safe Standards

Some organisations must meet the Child Safe Standards:

- Organisations and businesses in scope of the *Child Wellbeing and Safety Act 2005* must meet minimum requirements in each standard
- This includes organisations that provide or facilitate services for children (for some or all of their services)
- Requirements apply to sole traders if they have engaged a contractor / employee / volunteer to provide services

- ✓ There are 11 Child Safe Standards
- ✓ The Social Services Regulator regulates Child Safe Standards **in social services** that involve children
- ✓ There are **other regulators** of Child Safe Standards

https://www.vic.gov.au/changes-regulation-child-safe-standards

Our risk-based approach

We monitor compliance in a graduated, timely and proportionate way, and make decisions using:

- an intelligence-led and integrated approach
- objectivity and openness in our processes
- procedural fairness
- resources where they have the greatest effect

…using a data-driven approach to determine risk:

- ✓ Nature of service provided
- ✓ Profile of the service users
- ✓ Incident reports and handling
- ✓ Complaints and notifications from service users and the community
- ✓ Referrals from regulators and safeguarding bodies
- ✓ Announced and unannounced inspections

https://www.vic.gov.au/social-services-regulators-approach-regulation

Our co-regulators of the Child Safe Standards

Department of Health → regulates health services, including hospitals

Victorian Registration and Qualifications Authority (VRQA) → regulates schools and education providers

Department of Education → regulates early childhood education and care

Wage Inspectorate Victoria → regulates organisations that employ children and require a child employment license

Commission for Children and Young People (CCYP) → overarching responsibility and specific sectors
https://ccyp.vic.gov.au/child-safe-standards/regulating-the-standards/

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How we work with co-regulators

We may refer a concern about child safety to relevant co-regulators

In some cases, we work jointly with a co-regulator to regulate an organisation

We collaborate with co-regulators to improve information sharing and better identify and respond to risks of harm.

As an integrated sector regulator:

- ✓ There's an opportunity to align regulatory approach and share information
- ✓ There may be commonalities such as suitability of key personnel, governance and management, or complaint systems

Registration

Specific registration timeframes

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Registration – it’s a staged process

Registration timeframes

Social service	Group	Registration period
Community-based child and family services registered under the Children Youth and Families Act 2005	1	Automatically registered: 1 July 2024
Secure welfare services and community services provided by DFFH and created under section 44 of the Children, Youth and Families Act 2005	1	Automatically registered: 1 July 2024
Supported residential services	1	Automatically registered: 1 July 2024
Disability services registered under the Disability Act 2006	1	Automatically registered: 1 July 2024
Social services provided by DFFH, other than secure welfare services (such as child protection, forensic disability and Family Safety Victoria’s activities)	1	1 to 31 July 2024
Family violence services funded by DFFH	2	1 August to 30 September 2024
Homelessness services funded by DFFH	2	1 October to 31 December 2024
Sexual assault support services funded by DFFH	2	1 January to 31 March 2025
Disability services funded by Transport Accident Commission or Victorian Workcover Authority (WorkSafe)	3	1 April to 30 June 2025

https://www.vic.gov.au/social-services-regulator-registration

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Consultation

The Social Services Regulator is supported by a Consultative Committee led by Susan Pascoe AM.

Member	Organisation
Susan Pascoe AM	Independent Chair, Social Services Regulator Consultative Committee
Tania Farha	CEO, Safe + Equal
Allison Will	Executive Director, Regulation and Reform, in DFFH's capacity as system steward
Kathleen Maltzahn	CEO, of Sexual Assault Services Victoria (SASVic)
Sarah Fordyce	Victorian State Manager of National Disability Services
VDAC Member	TBC
Deborah Di Natale	CEO, Council to Homeless Persons
Linda Bamblett	CEO, Victorian Aboriginal Community Services Association
Deb Tsorbaris	CEO, Centre for Excellence in Child and Family Welfare
Colleen Pearce	The Public Advocate, Office of the Public Advocate
Juanita Pope	CEO, Victorian Council of Social Service

> The first meeting was on 13 September and will be held quarterly

Reference Groups

The Social Services Regulator will also have **three reference groups** to gain insight into their experiences and perspectives:

Providers

Lived experience

First nations

Membership of the reference groups is being determined

Getting in touch with the Social Services Regulator

For more information:

https://www.vic.gov.au/social-services-regulator

For further questions:

enquiries@ssr.vic.gov.au

Build familiarity about requirements under the six Standards: https://www.vic.gov.au/social-services-regulator-social-services-standards

Social Services Regulator

Questions

Thank you

Client voice project - Review of the independent person

Families, Fairness and Housing

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LIVING WITH DISABILITY
RESEARCH CENTRE

Review of the Independent Person Program

Presented by Prof Christine Bigby on behalf of Client Voice Project Team
Living with Disability Research Centre, La Trobe University

Client Voice Project research team:

- Christine Bigby
- Shih-Ning Then
- Alison Brookes
- Julia Duffy
- Laura Hogan
- Charity Sims-Jenkins
- Kathryn Bartlett

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Aims and Objectives of project

- Review and re-conceptualise the role of the Independent Person within the regulatory framework of restrictive practices for people with cognitive disability
- Review the Independent Person toolkit to assess efficacy

Project design

- Review of legislation and documents
- Interviews with people who have insight into the Independent Person role
- Stakeholder Advisory Group
- Lived Experience Advisory Group
  - Three women all subject to restrictive practices living in group homes (2 regional, 1 metro).
  - Project team member met separately with each of the women over past 8-12 months

Progress to date

- Ethics approval
- 2 Stakeholder Advisory Group meeting
- Lived-Experience Advisory Group established and meetings ongoing (three members, meeting individually).
- 21 interviews with
  - People acting as Independent Persons
  - Behaviour Support Practitioners
  - Disability Advocates
  - Authorised Program Officers
  - Family members of people with cognitive disability subject to RRP
  - Disability services managers (responsible for professional practices, quality, and safeguarding), and
  - Disability policy practitioners within state government (for example DFFH and OPA)
- Present - background - findings – proposals

IP key role - BSP with RRPs not approved without IP

- An **IP** is independent not connected to service provider, not paid supporter of person
  - Available to explain to the person the content of BSP, proposed RRP and the right to seek a review by VCAT and access an advocate.
  - Report to OPA or VSP if person does not understand RPP and there is breach of state or NDIS requirements
  - Possibly involved in development of BSP
  - Initial and reviews of BSPs with RRPs
- Way of meeting the practice standard - ensures person's involvement in BSP development and aware right to access advocate (NDIS Practice Standards Modules).
- APO must ensure IP is available and independent – Assist in review to VCAT if desired
- VSP approves Authorised Program Officers (APOs) for disability providers
- VSP approves use of restrictive practices (RRP)
- VSP available for advice to participants, APOs and IPs

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1. Disability service providers register with the NDIS Quality and Safeguards Commission.
2. APO must be appointed by the registered service provider approved by VSP
3. NDIS Behaviour Support Plan (BSP) by registered NDIS beh support practitioner - consultative process including the person, their family, and their carers
4. First time RRP used – interim plan within 1 month – comprehensive within 6 months
5. APO ensure IP available to explain to the person the BSP and rights in relation to the BSP.
6. APO authorises RRP - communicated to VSP
7. VSP approves RRP, if refused - APO communicates to beh support practitioner, revisions and repeat 4
8. Approved BSP, uploaded by beh support practitioner to NDIS.
9. APO within 2 days provides person copy of BSP, name of IP and review rights by VCAT – 28 days
10. APO monthly reports re RRPs to NDIS Commission. Unauthorised RRPs - Reportable Incidents to NDIS
11. Comprehensive BSP reviewed every 12 months or when change to RRP made.

What do people think about the IP role and processes

Valued its potential for safeguarding

  - Oversight of the BSP planning process and use of RRP – fresh eyes and more eyes – especially given low trust in competence of practitioners – people being left out of planning process
  - Represent the rights of the person – ensures they are the centre of plans
  - Supports the person to have their voice heard and or understand
  - Reinforces the gravity of using RRPs
  - Process to object
- Wouldn't be necessary if the system was working well

…it’s that extra layer of safeguarding available and having someone come in and yeah, just promote the rights and entitlement for review for that person. [8].

…We should be communicating to ensure that where we are infringing people’s human rights that there’s a meaningful conversation about it [5].

to ensure that they have good understanding of their restrictive practices, that they’re provided with opportunity to have feedback to contest [restrictions] to say “Hey, no! Actually, I don’t agree” [and] that they’re given that space to be able to feel supported and have their voice heard [9].

Experiences of IP – 'It's great but it's not great in practice'

- Many IPs do not fully understand the role, the regulatory context, the rights perspective, what constitutes a good BSP and RRPs
- May not have depth of understanding about person's communication, past trauma or negative experiences, underlying causes of behaviour
- Imposed time frames too short
- Mainly filled by family members
  - Works well sometimes
  - Some act as an advocate for person assuming they won't understand
  - Some perceived as having conflicting interests
    - unwilling to challenge staff
    - assume they are decision makers
    - some not in regular or close contact
    - some protective paternalistic stance

Lack of role clarity

There's a lot of characteristics that you need in [the Independent Person] which is very hard to find, because the amount of time that as an implementing provider we've got to spend with that person to give [support is limited] … we can give them information that's been made readily available, like the Independent Person Toolkit, but a lot of the time they don't read that …

… rather than understanding their purpose is to communicate what is being proposed and to ensure that all the requirements have been met [...] they see it as a guardian signing off on behalf of the person. That message of what's the intended role of communicating the proposed restrictive practices to the person has not been well conveyed or well understood [3].

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Potential … Intent … In principle … In theory

The whole point is that everybody knows that it doesn’t work, but it’s a great idea. Everybody knows. [The] legislation’s wonderful. It’s just never good in practice [11].

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Experiences of IP – ‘It’s great but it’s not great in practice’

- Not always working as intended
  - Difficulties finding someone to act as IP who is independent of services and knows the person well
    - Especially for people without family or not in close or regular contact
    - APOs limited capacity to search out IP
    - Role filled for compliance but often tokenistic
      - Only a cursory relationship – very limited knowledge of the person and the role
      - One off rather than ongoing relationship – advocate or student on placement
      - Not part of formal funding for advocacy organisations
      - No time to build rapport
      - Ethical issues of sharing information with relative strangers
- No continuity from plan to plan

I know that it’s often a family member … sometimes it can be a neighbour, it could be a family member of another person who lives in the group home but happens to know the person with a disability for some time. Sometimes when people are really desperate it’s been like, a hairdresser! [7].

… so many of our clients also don’t have family or friends within their support network. And so, oftentimes it’s being done by somebody who hasn’t met the client, who doesn’t have any idea about how to communicate well with a client in terms of how to ensure the client receives the information to get that feedback, those sorts of things. [9].

Experiences of IP – ‘It’s great but it’s not great in practice’

- Minimal and variable engagement and oversight by APOs
- No formal monitoring or reporting
  - Requires a tick and a name
- No record of there being challenges to VCAT
- Confusion re expectations of IP involvement in reviews of BSPs
- No face-to-face training or orientation or support – Tool kit dated and unclear
- Many not be involved in preparation of the plan – should they be?
- Time of VSP in providing info re IPs rough estimates
    - 2023 82/2650 3.10% (0-5.4%)
    - 2024 62/2360 2.63 (0.5-5.4%)

I think there's a real risk of a tick and flick, like just a tick box exercise. "Oh, we've just got to get this done, we trust the service, we trust everyone around the person are doing the right thing." And I think that's really dangerous. It's really, really dangerous because as much as services, most services, in the sector want to do a good job, there are also staff shortages [I16].

… I think the Independent Person has become a little bit of a tick the box over the last 10 years with the rollout of the NDIS, and it's not as overseen or regulated … or as seen as important compared to your authorisation processes and the bureaucratic steps [12].

It's a tick a box! So, you're legislatively required to put the name that an Independent Person has been consulted – I have found that year on year, a name has been put into the system as a person having performed the role. And when you unpack it, no they haven't. They may have, at a point in time years ago, and then it's been carried over … [3].

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Perspectives from lived experience advisory group members

- 1. Advocate as IP to support objection to inclusion of smoking restriction/cessation in her BSP (resolved within the house).

  '…liked having an advocate because they listened to what she wanted, not what others wanted.

- 2. Father as IP – good relationship – regular phone contact, in person 1-2 times per year but sees him as "too old and worn out to look after all the stuff for her."

  wants her counsellor to tell people what she wants…is unhappy about her medications and has not been able to get anybody to explain them to her…everyone should explain things and not just do them…has worked out a range of strategies with the counsellor to help when she is angry.

- 3. Cousin as IP - doesn't remember him, long term staff member (8 years) "has never laid eyes on him."

  doesn't like people making decisions about her…there should be someone on her side to tell her what is going on, not just doing things: especially important when decisions about others in the house impact on her.

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Key messages from 3 advisory group

- People know what they want but may not be able to achieve this; when asked about making choices the women go to “big” choices such as who they live with and note they are not allowed to decide for themselves.
- Having someone help to articulate their preferences – talk for them (such as an advocate) – is valued.
- Having input into what “medications” they take is important.
- Other people having information about them and not sharing it with them is wrong. If they don’t want to know something they will say so.
- People shouldn’t plan and decide things about them without being included.

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Underlying reasons for IP problems and tensions

Population

- Many people do not have close relationships with non-service others
- Explanation an unrealistic task with some people given severity of their disability and communication difficulties – morphs into advocacy [prior OPA report 19/25 people unable to engage]

Context / Administration

- Reliance on overstretched APOs to find, orientate, monitor and support
- No one owns it – no formal monitoring or reporting – can be simply ticked off
- Self serve training and orientation – Tool kit dated and unclear
- Short externally imposed time frames

Role

- Clarity – vagueness in legislation – friend, advocate, decision maker, supporter
- Demanding at best of time
- Heightened importance – increasingly complex expectations of BSP, format of BSP
- Diminishing trust in skills of Beh Support Practitioners and Providers

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Summary of issues identified

On the ground

- Potential value safeguarding – ensuring person centred practice – representing interests
- Not fulfilling intentions
- Lends itself to tokensim
- Growing need and importance of IP type of role

Design

- Was it designed for a different time - it is still fit for purpose ?
  - Is the explanatory role realistic role vis people with more severe intellectual or cognitive disabilities – should it be recast as an advocacy role
  - Are the depth of knowledge and understanding re context, BSP's and the person realistic expectations of close others
- No program presence training – advice – support – accountability
- Uncertainty who fulfils the role in absence of close family or other
- Is there a place for paid advocates or centrally organised volunteers

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Ideas for change

- **Adopt a stronger programmatic approach to role**
  - Central and more active oversight
  - Clearer articulation of role expectations, relationship with person and knowledge
  - Build in continuity
  - More proactive guidance and training – VSP or outsourced
  - Build central 'last resort capacity' – pilot paid advocate role
  - Investment in building relationships – sponsor citizen advocacy /communicator connector program – recognising long term nature of such programs
- **Law and Policy Reform**
  - Reframe as representation/advocacy role – widen mandate
  - Strengthen expectations – not simply to 'have available'
  - Influence by slow moving national uniform approach
  - Strengthen Client Voice requirements in BSPs – require evidence

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Thank you

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Morning tea

11:15am – 11:45am

Strengthening the role of the APO project

THE UNIVERSITY OF
MELBOURNE

Strengthening the role of the APO initiative:

Authorised Program Office Projects.

Dr Keith McVilly, Professor of Disability and Inclusion,
The University of Melbourne, School of Social and Political Sciences

Dr Paul Ramcharan, Scope-University of Melbourne Senior Research Fellow,
University of Melbourne, School of Social and Political Sciences

Tasha Haran, Team Leader – Integrated Practice Advisory Team

5th December 2024

Strengthening The APO Role

Strengthening the APO Role is an VSP initiative. The initiative is designed to:

- Deliver better skilled, capable APOs who are confident in their role
- Deliver consistency of approach in the APO role to reduce restrictive practices and deliver safety and better outcomes for people with disability
- Support APOs to understand their role within regulatory environments and legislation.

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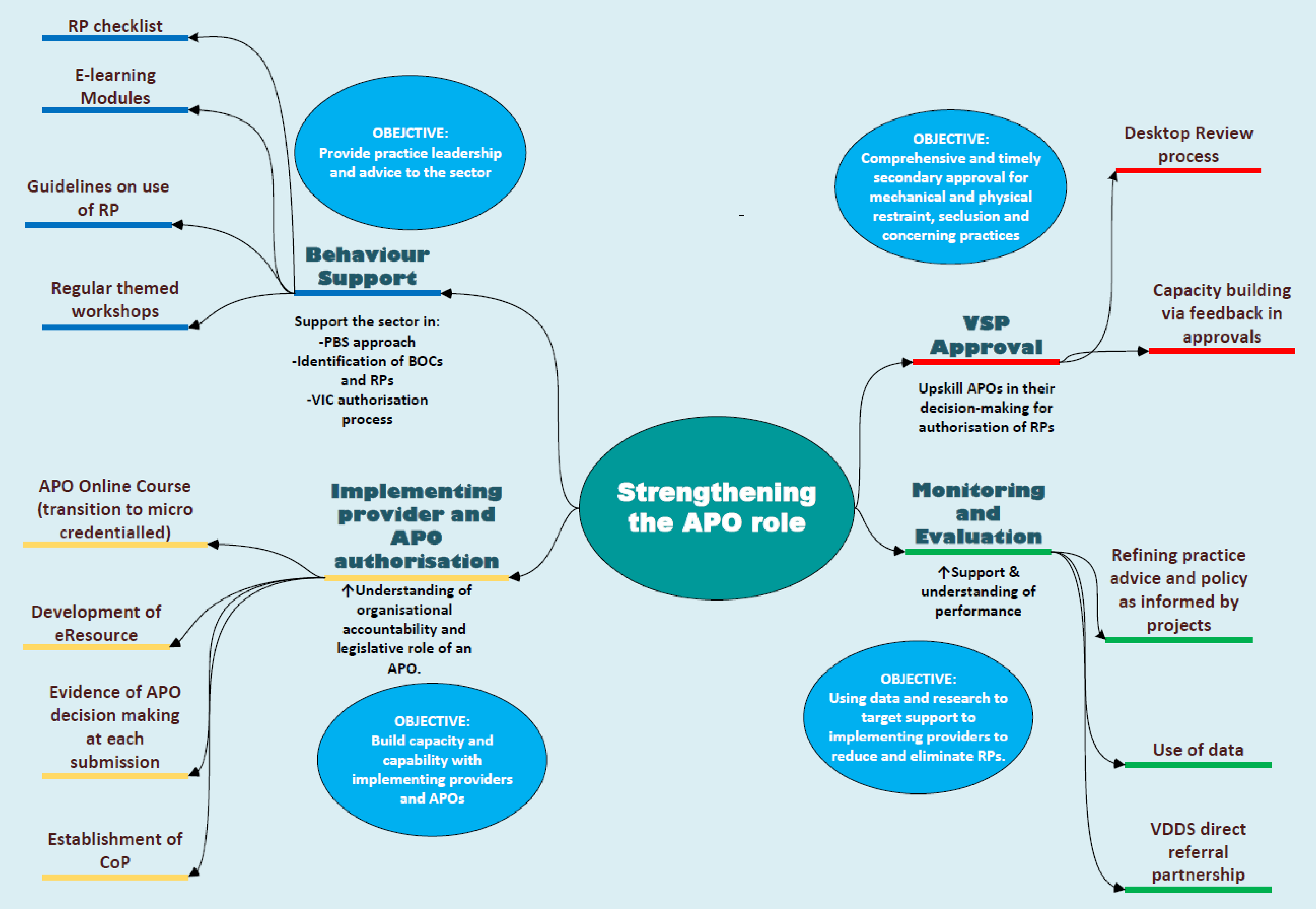
Elements of Strengthening the APO role

1. Behaviour Support
    - Support the sector in how to apply a PBS approach
    - Identification of behaviours of concern and restrictive practices
    - Understanding of the VIC authorisation process
2. Implementing provider and APO authorisation
    - Increase the understanding of organisational accountability and the legislative role of the APO
3. VSP Approval
    - Upskill APOs in their decision making for authorisation of restrictive practices
4. Monitoring and Evaluation
    - Increase support and understanding of performance through data

What we will do in this presentation

Deliver a latest update on the status of the various elements of Strengthening the APO Role:

- A summary report by VSP on activities to date including: the update of RIDS; changes to the system of authorisation; monitoring by Integrated Practice Advisory Team (IPAT) of submitted behaviour support plans; and work relating to provider and VSP APO appointment and registration processes.
- Talk about training for APOs
  a. The delivery of an online short course
  b. The development of a replacement APO micro-credential
- The development of a proposed Community of Practice for APOs



Strengthening the APO role

Behaviour Support

Support the sector in:
-PBS approach
-Identification of BOCs and RPs
-VIC authorisation process

OBEJCTIVE:
Provide practice leadership and advice to the sector

- RP checklist
- E-learning Modules
- Guidelines on use of RP
- Regular themed workshops

Implementing provider and APO authorisation

↑Understanding of organisational accountability and legislative role of an APO.

OBJECTIVE:
Build capacity and capability with implementing providers and APOs

- APO Online Course (transition to micro credentialled)
- Development of eResource
- Evidence of APO decision making at each submission
- Establishment of CoP

VSP Approval

Upskill APOs in their decision-making for authorisation of RPs

OBJECTIVE:
Comprehensive and timely secondary approval for mechanical and physical restraint, seclusion and concerning practices

- Desktop Review process
- Capacity building via feedback in approvals

Monitoring and Evaluation

↑Support & understanding of performance

OBJECTIVE:
Using data and research to target support to implementing providers to reduce and eliminate RPs.

- Refining practice advice and policy as informed by projects
- Use of data
- VDDS direct referral partnership

The APO short course – *Professional Development for Authorise Program Officers*

The APO short course was funded by DFFH and Keeping Our Sector Strong:

- Piloted in April 2020 and June 2022

- Designed to equip APOs with the foundational knowledge and skills necessary to effectively exercise their statutory responsibilities in the authorisation of regulated restrictive practices

- Improve the quality of BSPs

- reduce the use of regulated restrictive practices, to the betterment and well-being of clients subject to such restrictions.

- Course was delivered under a renewed contract from 2023 extending to June 2025

Summary of short course content

Between April 2020 and June 2022

- **Course length**: Ten hours contact time over ten weeks

- **Modules** 1- Roadmap for the Reduction of Restrictive Practices; 2 - Core Components of a behaviour support plan (BSP) – quality and compliance; 3 - Compulsory Treatment and the role of APOs in relation to Supervised Treatment Orders; 4 - Lodging BSPs into RIDS

- **Course outcomes**:
  - the health, well-being and quality of life of the persons subject to regulated restrictions for BSPs I have authorised is likely to improve;
  - the number of Functionally Equivalent Replacement Behaviours learned by people subject to BSPs I have authorised is likely to increase;
  - the number of regulated restrictive practices in the BSPs I authorise are likely to decrease;
  - the quality of life of people with disability will inrease

Summary of short course content

Between April 2020 and June 2022

- **Course competencies**: Confidence in Disability Act and can apply legislative requirements to BSPs; can apply human rights approach; know how to build a quality BSP; fully understand STOs; can submit BSPs to RIDS
- **Learning Management**: - FutureLearn learning management system. Videos, quizzes and discussion boards included
- **Surveys**: pre-course survey (exploring knowledge and perceived competence in relation to course objectives); post course survey (evaluating course and changes to perceived competence); 6 month survey looking at felt sense of competence around course outcomes in light of experience as an operating APO.

From July 2022 to present

- Transfer to Canvas learning management system hosted at the University of Melbourne with update of course content
- New Welcome webinar
- Introduction of a new Module – Reflective practice module 6 months after first four modules with online webinar and online discussion around experiences since completing the course.
- Four cohorts of 50 students each year who had been through a screening process at DFFH

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Key survey findings

- Demographic data indicate APOs tend to be mid-career and the majority were qualified at Diploma/Advanced Diploma or above
- An average of 24% had APO roles full-time. The vast majority balanced their roles with others.
- Course appraisal has been consistently very high in terms of: Module plan and lay out; presentation materials; engagement activities; information and course content; recommending the course to others.
- Changes in perceptions of competence have been at the highest level of significance (Time 1 survey before the course versus time 2 survey directly after the course
  - ➢ I am confident that I know all he roles, responsibilities and expectations of the APO under the Disability Act including changes made to the Act in 2019
  - ➢ I have a comprehensive knowledge about what makes a quality BSP
  - ➢ have a comprehensive knowledge about the legislative requirements of a BSP prior to submission
  - ➢ I fully understand the roles, responsibilities and expectations of an APO in relation to Supervised Treatment Orders (STOs)
  - ➢ I am confident I have a comprehensive understanding of how to submit BSPs into RIDS
  - ➢ fully understand and always apply human rights-based thinking in all my work as an APO? (slightly lower level of significance)

Key Findings (Cont'd)

A key finding, which led to the introduction of the Reflective Practice module and webinar six months after completion of core course modules was that:

- Confidence in achieving course outcomes reduced significantly in the six months in APO practice. Students had less confidence that they could: achieve better well-being and quality of life; could increase the number of functionally equivalent replacement behaviours; decrease the number of restrictive practices in BSPs and increase step-downs in BSPs.

So, why did confidence decrease? This was tested in the Reflective Practice webinar which was co-hosted with a member of IPAT. Key issues were:

- ❖ Staff – knowledge and attitudes, push-back, making sure BSP implementation takes place
- ❖ Behaviour support practitioners – constantly changing, out-of-state, access (esp rural areas) and time management, simply replicating old BSPs, reporting and documenting, discussions on reductions and elimination difficult, notably over time APOs report spending more time doing training with practitioners on reducing restrictive practices, statutory requirements and positive behaviour support.

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Key Findings (Cont’d)

- Time and resources – Reporting has increased and doubles up with RIDS and PRODA, complex BSPs are time-heavy, line-item funding runs out, difficulties chasing stakeholders and secondary providers
- Resistance of other professionals – particular issues with medical practitioners and reducing drug regimes, secondary providers will not agree and threaten service withdrawal if a restrictive practice is not in place, running out the clock on timely submissions, families, Guardian or nominee does not agree to the Plan
- Organisational – misunderstandings of APO role within the organisation, employer sees role as “submitting BSPs”, lack of management support leads to pressure to go with a BSP.

APOs find themselves in a ‘liminal space’ – part of their organisation but doing the work of VSP. It is a difficult space. There is recognition of the need to develop their skill set in light of ongoing practice change.

…and finally, 743 enrolments since start with a 62% completion rate.

The move to a Micro-credentialed course.

- Recognition that although the previous short course students were issued a certificate, it was not badged nor credentialled. So there is a need to move to an accredited course which gains credit points that can be collected towards a university qualification.
- The need for a renewal and refresh in light of changes at VSP and the regulatory environment
- The need to uplift the skillset given evidence on the increasing complexity of their task

- One of a number of courses with a micro-credential that are run through University of Melbourne
  - Positive behaviour support, Part 1 (Core practitioners)
  - PBS: Assessment and Planning
  - Autism Affirming Behaviour Support (Specialist Practitioner)
  - Forensic Disability be haviour Support (Specialist practitioner

Authorised Program Officer (APO) Professional Development Micro-credential

- 2 credit point course
- 25 hours of learning – 10 hours of Guided Learning and 15 hours self/peer learning
- Two formal assessment tasks (to replace engagement activities and quizzes) 900 word equivalent with two linked webinars
- FlexiAccess - 4 teaching periods per year from June 2025 with 12 weeks for each teaching period. Students can enrol at any point during the first 6 weeks.
- Access to the course through screening at DFFH
- VSP will authorise new APOs in their role only after course completion
- All course materials will be evidence-based and evidence informed. A wish to up the standard of learning and skills application and link it to best evidence.
- Ongoing discussion about Recognition of Prior Learning for students from the previous course

Authorised Program Officer (APO) Professional Development Micro-credential Cont’d

- Learning Outcomes:
  - Examine role expectations, including legislative and administrative requirements for the oversight of Behaviour Support Plans and strategies relating to regulated restrictive practices.
  - Apply best practice principles to critically review and propose enhancements to Behaviour Support Plans, using a human rights informed and evidence-based approach to deliver quality behaviour support practice and positive outcomes for people with disability
- Modules:
  - Module 1 –The legislative and administrative environment - Jurisdiction specific (e.g., Victoria) legislative and administrative requirements for APOs
  - Module 2 – The characteristics of a Behaviour Support Plan – Human rights, quality BSPs
  - Module 3 – Technical and practical applications – evidence supporting good behaviour support planning including PBS, Practical advice on working in teams and secondary provides to negotiate plan content, restrictive practices and fade-out.

New course to start July 2025 !!

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An APO Community of Practice?

One recommendation that came out of the APO short courses was the need for a Community of Practice for APOs. There seemed to be enthusiasm from APOs and many requested continued contact.

The APO community of Practice project explored the potential for the delivery of a CoP by

- Undertaking a literature review on how best to deliver a Community of Practice
- A web-survey of APOs to explore their preferences around a CoP
- Running a pilot CoP
- The delivery of a proposal to VSP in relation to the feasibility, cost and practical arrangements for ongoing CoPs.

The work was led by Dr. Carmel Laragy. A group of leading APOs acted as a project advisory group

Summary findings from the literature

- 91 articles reviewed from a search of Scopus and Social Care Institute of Excellence (SCIE) using community of Practice and disability as search terms (but including associated disciplinary fields)
- Benefits of CoPs – share experiences, learning from each other, providing support, increasing confidence, reducing isolation, opportunity to voice opinions and new ideas and gauge feedback
- CoP success strategies – common aims, adapting delivery models and processes to demand, organisational (employer) support, building a trusting environment, *building capital over time*; support structures, adaptive governance, skilled facilitator to introduce topics, facilitate peer discussion and integrate discussion summaries.
- Online CoP success strategies – active leadership team, technical support, rules of engagement, other social media and information contact between meetings

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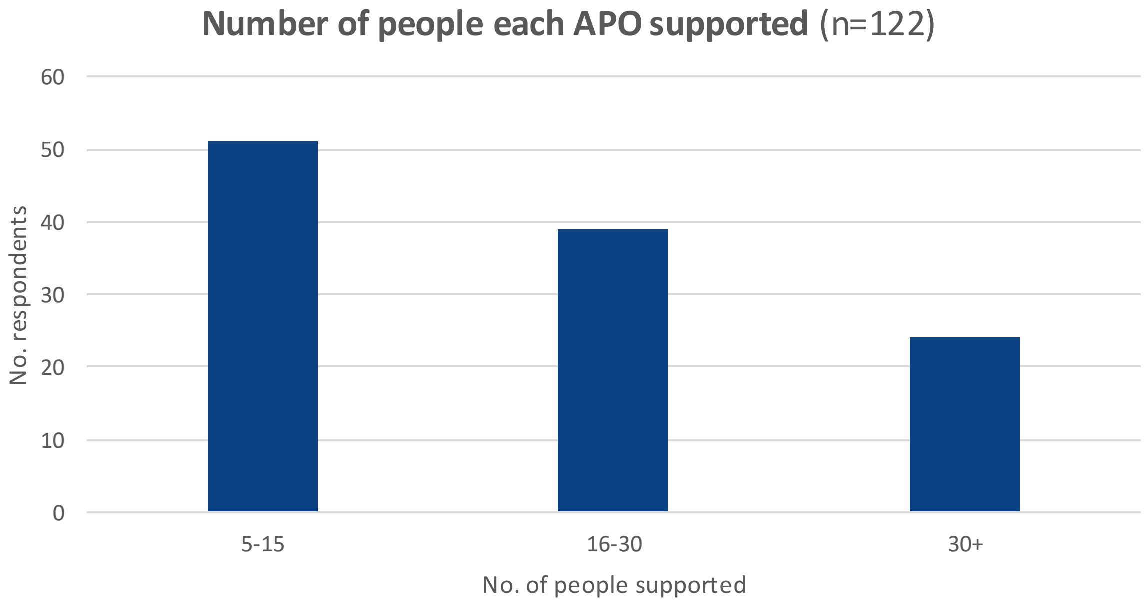
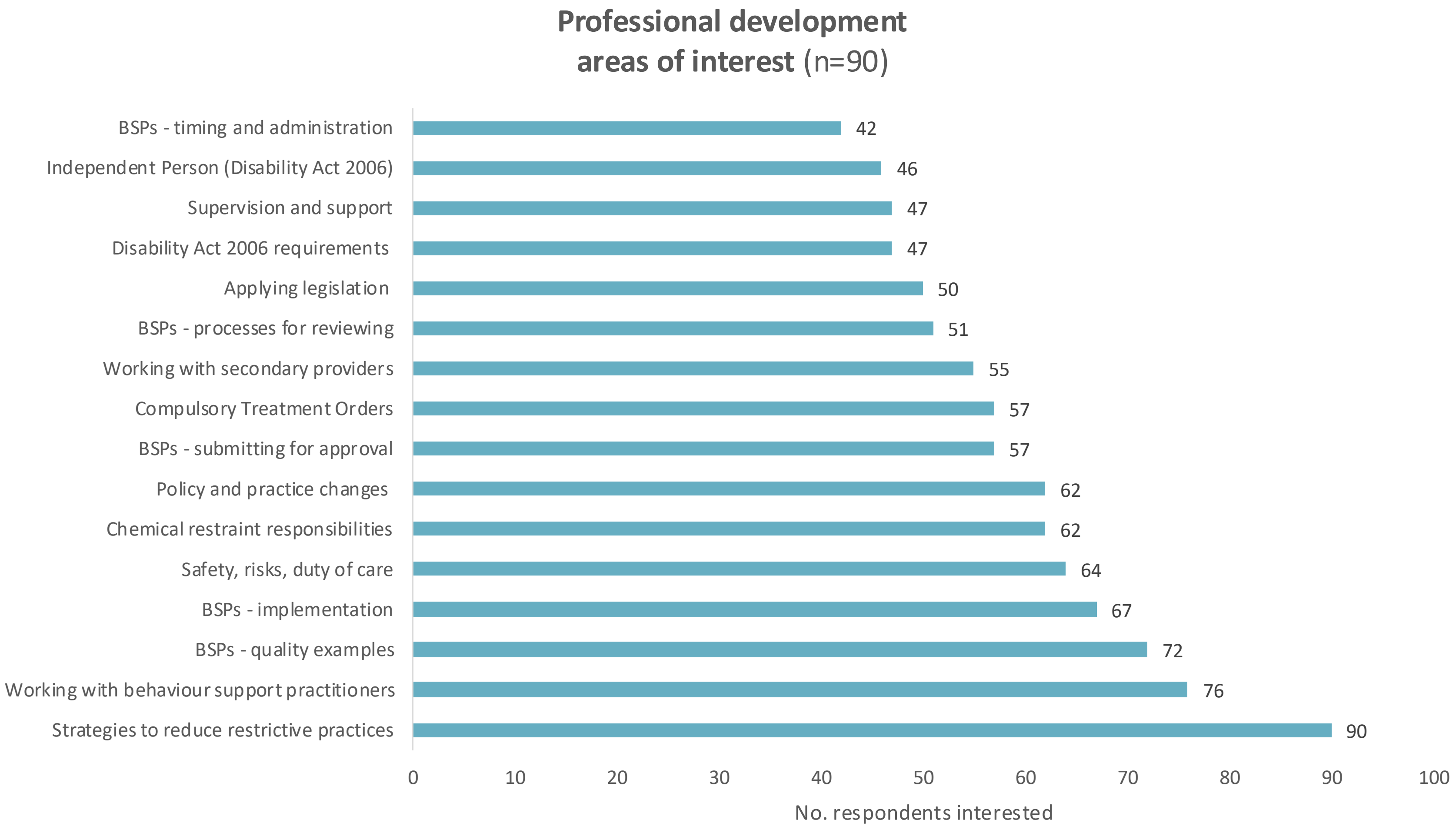
Online survey and key findings

- Sample frame – 900 or so APOs listed on RIDS, 129 completions
- Delivery by Qualtrics and all anonymised
- Ethics successfully granted
- Similar make up to APO course data with a distribution of education with 31 Cert 6 or below; 43 at Diploma/Advanced Diploma; 54 at degree level and 5 with a higher degree.
- Number of people supported in APO role:


Number of people each APO supported (n=122)

Online survey and key findings

Areas of interest for professional development:



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Online survey and key findings

Preferred method for professional development (n=101)

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Online survey and key findings

- CoP meeting preference - 56% preferred online, 42% blended online and face-to-face and just 2% face to face
- 86% did not think level of APO experience should dictate the design of CoP meetings
- The majority (62%) wanted a designated convenor but were slit around whether that should be a VSP worker or someone independent
- Frequency of meetings – 48% said quarterly 25% bimonthly and smaller numbers for other options.
- Preferred meeting time – Lunchtime 53%; early afternoon 38%; other times were much smaller
- Group size did not matter to 48%

Pilot CoP

- 18th September 12.-1.00 p.m. notification to all APOs – 168 attendees
- Focus on Chemical restraint delivered by Connie Wu and questions, break out groups and then feedback and then a poll about preferences for the future
- Learning: Technical support is essential for online meetings; large number require large numbers of facilitators; Auslan may be required; some people could not use chat function and needed prior instruction; simple things – please mute – poll stopped when meeting time ended.
- Attendees liked that the question was set in advance, people registered an appetite for more sessions, feedback was positive, people asked whether the recording could be kept online and whether there was an associated online discussion space outside of meetings

Into the Future

1. Based on the findings of the CoP initiative a proposal currently sits with VSP for consideration. It would include not just quarterly meetings, but a governance structure, a moderator post, tech support and an online meeting place for APO discussions.

2. The development of an APO e-support resource in 2025 covering areas that have not yet received attention through all other aspects of the Strengthening the APO Role initiative and giving direct access to useful information and websites.

Thank you

Questions?

Physical restraint project

Physical Restraints: A ten-year review and future policy development.

5th December 2024

Dr Paul Ramcharan, Senior Research Fellow,
University of Melbourne, School of Social and Political Sciences

Dr Keith McVilly, Professor of Disability and Inclusion,
The University of Melbourne, School of Social and Political Sciences

Dr Erin Leif, Senior Lecturer and Associate Head of School,
Department of Educational Psychology and Counselling, Monash University.

Background

- Commissioned by the Victorian Senior Practitioner.
- To investigate and propose policy and practice solutions to build on work originally undertaken by Victorian Senior Practitioner in 2009 and to address emergent concerns:
  - ☐ the misuse of physical restraints and the subsequent adverse impact on people with disability;
  - ☐ confusion about the use of physical restraint in the exercise of a person’s duty of care to safeguard people with disability and;
  - ☐ possible effects on the frequency of the use of physical restraint arising from changes to the regulatory framework associated with the transition of oversight to the NDIS Quality and Safeguards Commission.

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Five research questions.

Q	Question	Method
1	What has been occurring in Victoria with respect to the reporting of physical restraints over the past 10 years, and what might account for any such trends?	Analysis of RIDS data over ten years
2	What is considered to be contemporary good practice in policy concerning the use of physical restraints in disability and related services (e.g., mental health & aged care) and what evidence exists for the successful reduction and / or elimination of such practices?	Formal academic and grey literature review
3	What are the experiences and major concerns among *disability service providers* with respect to the implementation of policy and subsequent practices designed to reduce and wherever possible eliminate the use of restrictive practices, including concerns about occupational violence, and the understanding (and potential confusion) with respect to issues of the physical restraint of clients in the exercise of an organisation's '*duty of care*'?	Survey behaviour support practitioners, interviews with managers and APOs
4	What are the *experiences and major concerns among people with disability and their families* with respect to the implementation of policy and subsequent practices designed to reduce and wherever possible eliminate the use of restrictive practices?	Focus groups with people with disability and family carers
5	How might what we have learnt about the reduction and elimination of physical restraints be translated into a stronger policy and practice framework that can be agreed upon and implemented safely and successfully in the disability sector?	Integration of all data and an inclusive codesign workshop

What we shall do in this presentation

1. Present some *key observations and findings* from each of the five project questions and research activities
2. Point to some *key recommendations*
3. Take *audience questions*

Note: We cannot cover everything we have found in this presentation, so if there are areas you note have not been covered, do ask!)

Summary Findings – Research question 1

What has been occurring in Victoria with respect to the reporting of physical restraints over the past 10 years, and what might account for any such trends?

1. The number of physical restraints compared to the total number used at least once in any year is very small
2. The reporting is inconsistent across time in terms of what is reported in the Annual reports
3. The number of people who are subject to a physical restraint as prn is very small compared to the total number of people with disability subject to differing types of restraint.
4. Several explanations for change in data were provided in the reports.

It was concluded:

1. There are too many inconsistencies across the datasets over the years since 2014/15 to report changes to use of physical restraint over time in a valid way.
2. Changes in regulation and number of organisations reporting over the years make comparison difficult.
3. The issues with inconsistency are multiplied given the small number of people who have been subject to a physical restraint. As a result, if one person has been subject to a number of physical restraints, if they drop out, it has a disproportionate impact on the percentage change in the use of physical restraint over time
4. The lack of data since 2019 (NDIS) makes it even more difficult to compare numbers across time.

Summary Findings – Research question 1 (cont'd)

1. Since the move to NDIS in 2019, there are now two systems of reporting each of which is taking up valuable behaviour support time and less time to work on plan implementation
2. The NDIS-QSC data is not being made available to states and territories. The data collection appears to focus on regulatory compliance. Planning & strategizing are therefore very difficult
3. It was not possible to assess whether the NDIS category of 'routine' use of physical restraint in a BSP had the effect of 'increased the use of physical restraint'. The NDIS examination of BSPs showed confusion by APOs around different forms of physical restraint, giving rise to further issues around the reliability of reporting
4. A concern about whether the category 'routine' use as opposed to 'prn' use under NDIS rules had increased the number of physical restraints used. The data provides a confusing picture. Our survey of practitioners indicated perceptions of change: 26% felt the use of routine physical restraint had increased, 41% that it had decreased and 32% that it had remained steady.

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Research question 1 – preliminary observations

1. There is a vital need to 'redefine the solution space' – current data may not be measuring the right thing, nor might it be accessible to the right people for the right reasons.
2. Research participants generally agreed that if the aim was to reduce and eliminate restrictive practices that data needed to be collected on reductions, step downs in use and outcomes. Information needs to be made available on *what had led to such successes*.
3. As will be suggested later when we consider the BSP, as a *collaborative team activity*, this will require database accessible for teams as well as aggregated data for VSP use. Ie. accessible to support workers, people with disability and family in relation to their own data. This would keep people motivated to stay involved and to monitor change.
4. Our codesign partners including people with disability and family carers wanted to know why VSP does not harvest information on physical restraint from other sources Valid8 or OPA community visitors or other places can test of the 'temperature' in the sector as well as VSP's own formal data collection.

Summary Findings – Research question 2

What is considered to be contemporary good practice in policy concerning the use of physical restraints in disability and related services (e.g., mental health & aged care) and what evidence exists for the successful reduction and / or elimination of such practices?

The literature review identified 23 studies relating to reducing the use of physical restraints each of which had evidence of success that can be added to future best practice guides.

Evidence of what works included:

1. A number of multicomponent models: No Force First , Safewards, ReSTRAIN, SAMSHA
2. Single intervention studies: Mindfulness techniques; reflective practice; fixed-time release reductions and step downs of physical holds

But was not clear whether:

- These were well known and adopted throughout Victoria
- Success had been proven in non-controlled non-experimental settings
- Whether any longitudinal monitoring of innovative interventions had been undertaken to continue to test their efficacy.

Summary Findings – Research question 2 (cont'd)

The **review of grey literature** confirmed our broader finding that a reduction or elimination in the use of physical restraint required a multi-component approach combining a number of interventions and organisational changes.

Success reflected changes relating to:

- Staff
- Organisational policy
- Quality of practice
- Engagement with family
- Adoption of clinical intervention
- Pursuing models of change (as previously reported)

Notably - the findings also emphasised that the approach taken must be individualised to the person concerned.

Summary Findings – Research question 2 - Further work

The literature in the Physical Restraint Directive and NDIS Rules emphasise the damage physical restraint can do. Much of this relates to physical harms.

We also undertook a review of psychological and emotional harms. We found:

- The emotional harm of using a physical restraint can be serious.
- In the short term physical restraint may cause emotions which give rise to further behaviours that then become a focus for more physical restraint
- In the long term emotional responses may manifest as trauma and mental health problems
- Evidence shows the therapeutic relationship suffers after a physical restraint is used and this may not be recoverable. If trust is lost it is a major loss for the person and can further impede opportunities for learning new skills and behaviours.
- We found that after use of a physical restraint people *need space for self-regulation*.
- People with disability said they needed a *'sanctuary space'.* They also need people with whom to share their emotions. This can mean *more than just debriefing*.

Research question 2: Preliminary observations

- There are many potential ways to reduce or eliminate the use of physical restraint. It is not clear that there is *ongoing guidance about models* that show promise nor that disability or NDIS registered provider organisations are aware of the possibilities and implement new approaches
- There is a disconnect between proven best practice interventions and best practice adoption on the ground. Some mechanism is needed to connect the two.
- As reported previously it is not clear whether applying these interventions in individual cases has been monitored and whether it makes a difference. Linked to previously suggested data systems recording the success of different interventions can be hugely useful to directing future policy and practice. This is another important inclusion in the ‘solution space’ that needs to be addressed and how the links between research policy and practice work dynamically together and how success is made public
- More focus is required in relation to the emotional response of experiencing or witnessing a physical restraint – for people with disability and support staff.

Summary Findings – Research question 3

What are the experiences and major concerns among *disability service providers* with respect to the implementation of policy and subsequent practices designed to reduce and wherever possible eliminate the use of restrictive practices, including concerns about occupational violence, and the understanding (and potential confusion) with respect to issues of the physical restraint of clients in the exercise of an organisation's '*duty of care*'?

The literature review pointed out how important organisational and systemic factors are. Survey of practitioners and interviews with manager and APOs in disability and NDIS-registered services found:

1. Whilst 72% survey respondents did not support a person with physical restraint in their BSP, 77% of survey participants had heard of unauthorised use of physical restraint, not approved by the Victorian Senior Practitioner
2. Physical restraint (authorised or unauthorised) was reported to be used to in response to concerns about: safety of the person, safety to others (staff, family, members of the public), road/traffic safety, resident-to-resident assaults, and to facilitate access to medical care and personal care
3. System that fine organisations and people do not work. We need systems that lead to openness and positive change through learning
4. The level of bureaucracy needs to be addressed now there are two reporting frameworks. Not doing so takes away time from implementation and monitoring of plans.

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Summary Findings – Research question 3

What are the experiences and major concerns among *disability service providers* with respect to the implementation of policy and subsequent practices designed to reduce and wherever possible eliminate the use of restrictive practices, including concerns about occupational violence, and the understanding (and potential confusion) with respect to issues of the physical restraint of clients in the exercise of an organisation's '*duty of care*'?

1. Organisational systems for reducing physical restraint were not perceived as being well established by respondents
2. Reasons for the continued use of physical restraint were: Lack of training and skills (32%); attitudinal barriers (37%), Belief physical restraint is necessary (34%), Lack of resources (21%), Wanting a quick fix (19%), organisational culture (15%), lack of awareness (11%), inadequate oversight (6%)
3. Perspective on things that had worked to reduce the use of physical restraint – training (esp practitioners), positive behaviour support, better regulatory information and support, ensuring plans are implemented by staff and families

Research Question 3 – Preliminary Observations.

- Professionals perceived there to be a **lack of clarity and consistency** in definitions and classifications of physical restraint across different states, territories, and service systems.
- Physical restraint was sometimes being written into behaviour support plans "**just in case**" or at the request of families and day service programs.
- Physical restraint was observed to be occurring in **family homes**.
- **Resistance or lack of cooperation** from families or carers can pose significant challenges, particularly when they may be accustomed to certain practices or have different perceptions of what is acceptable.
- Professionals struggled with the need to balance the **rights of the person** with disability with the rights of staff/families to be **safe from harm**.
- Professionals were concerned about **burdensome reporting procedures** and an overemphasis on compliance (over quality support).
- Professionals sometimes avoided the use of physical restraint by **using other RPs** or by calling **emergency services** to intervene.

Summary Findings – Research question 4

What are the *experiences and major concerns among people with disability and their families* with respect to the implementation of policy and subsequent practices designed to reduce and wherever possible eliminate the use of restrictive practices?

We undertook three focus groups and used five videos of differing physical restraints to prompt discussion amongst family carers and two groups of people with disability, one having experienced physical restraint and the other not.

Key findings were:

1. Many people simply did not know enough about what a physical restraint was, and which restraints were banned.
2. We identified a number of principles from our discussions.
3. The groups also emphasised what needed to happen after an emergency restraint. They felt the ‘gap year’ had lots more potential untapped and working with the person, family carers and others was vital during these phases.
4. Many people observed cultures of micro-aggression and micro-control

Research question 4 – preliminary observations

- Choice and control and communication are at the very heart of all disability support and ways of achieving these and providing meaningful lives through every moment need to be a part of the training that prevents behaviours and the use of physical restraint
- People with disability and family carers need to know more about physical restraint – what is banned and circumstances relating to what is allowed
- Working with people with behaviours takes time and ***teamwork***
- The BSP development process needs to be inclusive and not professional. This should be a team activity
- People with disability and family carers are willing and able to provide training and be part of the policy making process
- Systems of complaint need to be equal strength to the organisations against whom complaints are made.

Research question 4 – preliminary observations

Principles.

- Violence only produces more violence and nobody wins
- Physical restraint is not only dangerous physically – it leaves scars on emotions and can damage the client-staff relationship
- Be clear about the definitions of physical restraint and duty of care responses.
- Choice and control are a real key to better behaviours in all relationships
- Communication, active listening, respect are crucial
- Make people's lives more comfortable and free – every moment has potential
- Make sure complaints can be made and are addressed and listened to
- Learn to recognise and respond appropriately when people are sad, emotional and angry
- Staff must know the person for whom they provide support
- Make sure staff have information about how to know when physical support and guidance change into physical restraint
- Change attitudes of staff to people with disability and to behaviour support
- Start by changing *staff* behaviour - Physical restraint should not be used when staff are - angry, as threat, avarice, for sole personal gain of the person using force, for revenge, retribution, reprisal, retaliation, vengeance, loathing, disgust, hatred, for punishment, as a sentence or penalty, or, as a 'drill' or 'regimen' such as in an institutional setting
- Unless under supervision, no use of physical restraint by untrained staff
- Openness about unauthorised use of physical restraint should be accompanied by support and resources and a 'no blame' approach to begin with (though excluding instance of abuse or illegality).
- Stop collecting data that is not used – the most essential data is whether physical restraints have been reduced or eliminated
- Look at the causes of behaviours that lead to physical restraint not just in the person but in the environment and interactions around them
- Protect and support development the person's chosen identity.
- Involve people with disability and family carers to do training and in policy development.
- **Work as a team on behaviour support**

Preliminary observations– Research question 5

How might what we have learnt about the reduction and elimination of physical restraints be translated into a stronger policy and practice framework that can be agreed upon and implemented safely and successfully in the disability sector?

- We ran a 2-week online codesign group where people were able to make contributions in relation to a number of key questions and findings from previous phases of the research.
- We then ran an inclusive day-long co-design workshop to test ideas and solutions.

The group came up with a number of suggestions as follows:

1. Solutions to be based in the UN Convention on the Rights of Persons with Disability.
2. Some felt physical restraints should not be banned and are needed where they are the ‘lesser of two’ evils (critical medical treatment, running into traffic) but such situations *needed specific guidance and decision-making tools*
3. There were many ideas to reduce and eliminate physical restraint (covered in summing up later).

Preliminary observations– Research question 5 (cont'd)

4. Principles rehearsed earlier were confirmed and additional principles: openness around use of unauthorised use; data collected must help what is happening and how to respond; a focus on environment; emphasising *the right to review* where human rights are an issue; addressing casual and short terms staff who cannot 'know the person'.
5. Definitions of physical restraint need to be more clear - since the same action can be physical restraint in one circumstance and not in another, people need a *compendium of alternatives and detailed examples* of how to make decisions around risk (its often context not action!). *Decision-making and flow charts* and *tools around 'circumstances' and 'contexts*' linked to adoption of a restraint might help. These also need to identify the *crossover point* between reassurance, assistance, guidance, protection and restraint.
6. Recommendations on data: Common dataset accessed by behaviour support team and can be aggregated and accesses by BSP team, VSP and providers; nothing that is not needed; positive focus on what solutions work, focus on (monitor & report) step downs and outcomes; background data on disability type skills and abilities – all widely shared in Guidance

Preliminary observations – Research question 5

7. People with disability and family carers
   - More engagement in policy and training
   - Elevate the voice of people with disability and family in case studies
   - Link to data collected by advocacy groups, OPA, DSC, carers' organisations
   - Provide more consistent training and support to families

8. Better systems for complaints – monitoring for those who do not/cannot speak for themselves (e.g. Independent Person) - A Safeguarding officer working through VSP may be useful. Advocacy and Independent Person should monitor and alert services about issues. A campaign like DSC's 'It's Ok the Complain' might help

9. Authorisation issues and questions on whether physical restraint should ever be in a BSP – Suggestion for *Authorisation Panel* (like ACT/NSW) as will be discussed shortly

10. A host of suggestions were made relating to disability and NDIS registered services (covered later).

Concluding remarks and recommendations

1. Consider and adopt the principles outlined earlier (and making sure they are in plain language)
2. A primary focus on choice, control and human rights of each person subject to physical restraint
3. Separate Prohibition and Guidance documents; be clear about what are and are not physical restraints
4. Identify 'duty of care' in terms of a human rights choice framework or the 'lesser of two evils' and provide examples with context/circumstance and a decision-making tool which includes risk and provides case studies.
5. Include policy on trauma informed care with a focus on emotional harms and how to create space for self–regulation and sanctuary.
6. Behaviour support planning should not be seen as a 'professional' only activity – ideas around 'Team' including people with disability, family carers and others can increase engagement, monitoring and engagement (including access by all to data). There should also be *easy read BSPs*.
7. An interim BSP between emergency use and BSP development and contact with the suggested *physical restraint panel* for advice would provide a system of best practice aimed at avoiding physical restraints appearing in the BSP. It would also provide checks and balances over this process and ensure rights are protected, defended and promoted.

Concluding remarks and recommendations (Cont'd)

8. A trial period for a Physical Restraint Review Panel (like ACT/NSW) as part of the authorisation process
9. A 'No Blame' focus on unauthorised use and micro aggressions and control within organisations
10. A review of data collection (and discussions with NDIS-QSC also) - Data collection with a focus on step downs, reductions, elimination and successful outcomes – available to different groups for personal use, for aggregated use, and linked to appreciative inquiry reporting of what works, when and in what circumstances.
11. Address issues around Duty of Care with Guidance documents
12. Mend the gap between theory and practice –harvesting good practice and making public successful approaches to preventing physical restraint (a 'what works approach'). IPAT could also monitor new models and intervention studies and, where the Panel suggests, launch tests of efficacy prior to wider recommendation to adopt in certain defined circumstances.
13. New Guidance to disability and NDIS-registered providers to adopt zero-tolerance approach, to consider Advanced Directives, service agreements which commit to a position on use of physical restraint, operationalisation of a 'No Blame' approach as well as how to link with the Panel.
14. Policies on staff safety and care of staff who undertake this work in challenging circumstances.

Thank you

Questions?

Lunch

1:15pm – 2.15pm

Existing barriers to safely integrating people with disability at risk of offending back into the community project

Building the foundations of rights-based behaviour support project

VICTORIA State Government | Families, Fairness and Housing

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Building the foundations of rights-based behaviour support: The development of service guidelines for SIL providers

Dr Alinka Fisher
Disability & Community Inclusion
Flinders University

VICTORIA State Government | Families, Fairness and Housing

Government of Western Australia Department of Communities

QUEENSLAND GOVERNMENT
Department of Communities, Child Safety and Disability Services

NDS National Disability Services

MONASH University

Acknowledgements

- Department of Families, Fairness and Housing; Mandy Donley and David Henderson
- Project partners: Monash University, Department of Communities (WA), Department of Communities, Child Safety and Disability Services (QLD), National Disability Services
- Co-design group: People with disability, family members, SIL providers

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What we know

- High occurrence of behaviours of concern
- High demand for behaviour support practitioners
- Limited PBS expertise; need for training/education
- Compliance focus and reactive approach

Urgent recommendations for preventative practices that uphold and protect a person’s rights

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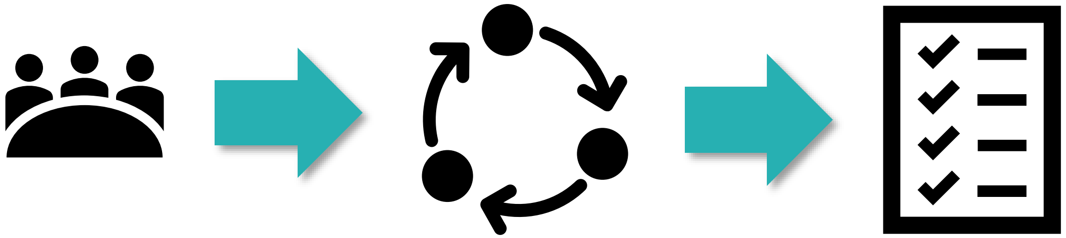
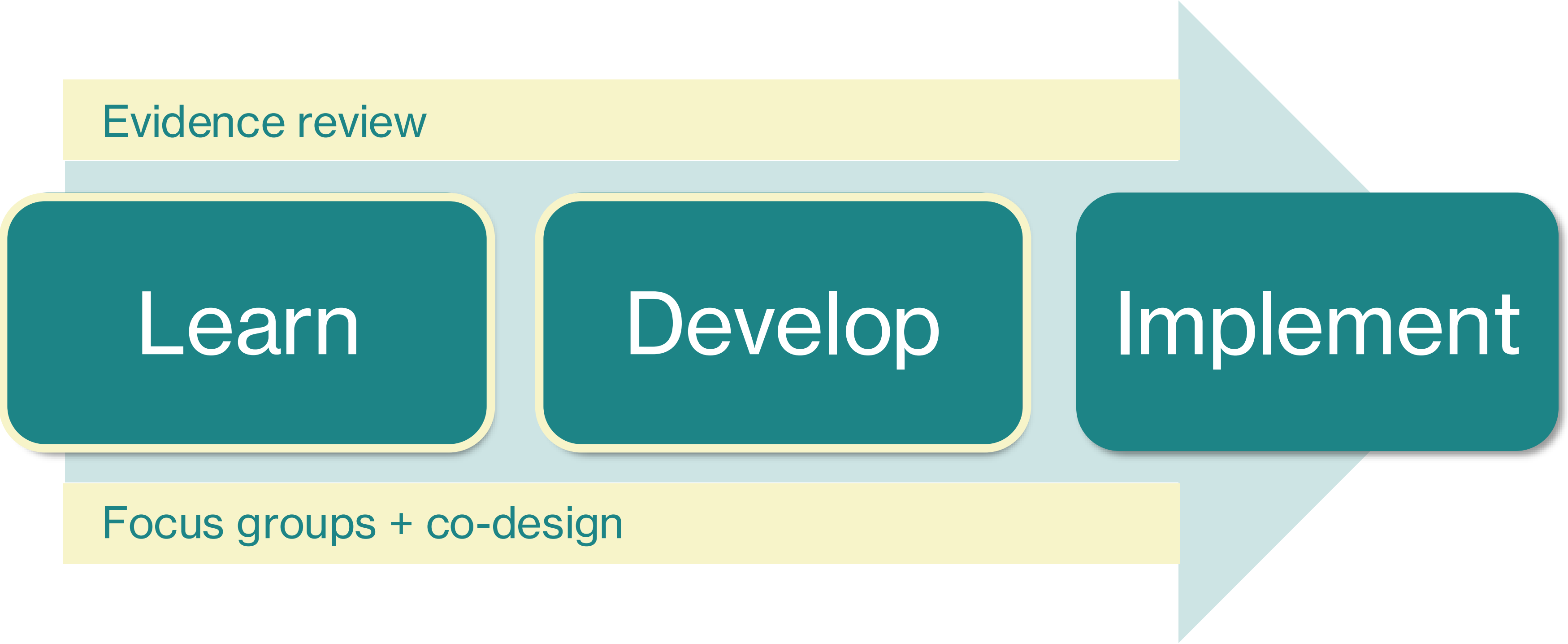
Aim

To develop evidence-based service guidelines (minimum expectations) for rights-based behaviour support for people with disability in SIL.



Process



Evidence review

Learn

Develop

Implement

Focus groups + co-design

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Disability Discrimination Act 1992.

National standards for disability services

NDIS Act 2013

NDIS Provider registration and practice standards rule 2018

NDIS Restrictive Practice and Behaviour Support Rules 2018.

NDIS Quality indicators for NDIS Practice Standards Guidelines 2018.

NDIS Codes of Conduct

NDIS practice standards and quality indicators

The NDIS Workforce Capability Framework

SIL Provider

What is required of me?
What are expectations of my role?

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We need foundation supports!

Foundation supports!

Foundational supports!

But what are they..?

Active supports!

Capable environments!

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Foundation Supports

What are a person’s rights?

What supports are considered minimum expectation in upholding these rights?

“The fundamental systems, structures, and practices that ensure equitable access, inclusion and self-determination for all people. They uphold the right to a life reflecting personal values, will and preferences, and acknowledge and respond to a person's history, culture and experiences.”

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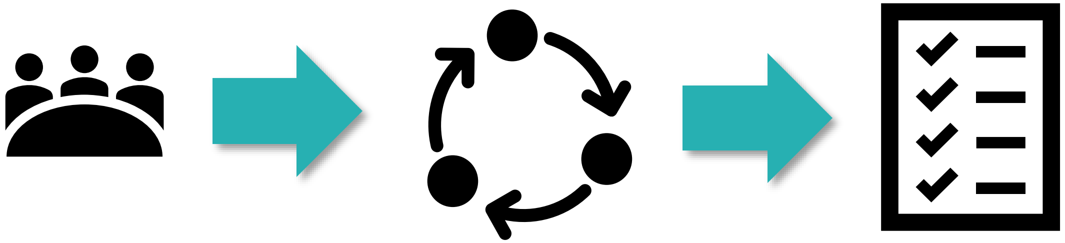
The foundations of rights-based behaviour support

- Foundation supports that reduce the need for specialist/intensive behaviour support
- A preventative approach that seeks to improve the environment and uphold a person's rights

Co-design process

People with disability and family members

Service providers (managers, team leaders, support coordinators, support workers)



People with disability

What are my rights? What can I expect?

Support workers

Practice/team leaders

Service managers

What are the person’s rights?
What are my roles/responsibilities in actualising these rights?

What we've learnt....

And what next

Flinders University

Thank you

Flinders University

A better day – A promoting dignity grant project

VICTORIA
State
Government

Families,
Fairness
and Housing

A better day

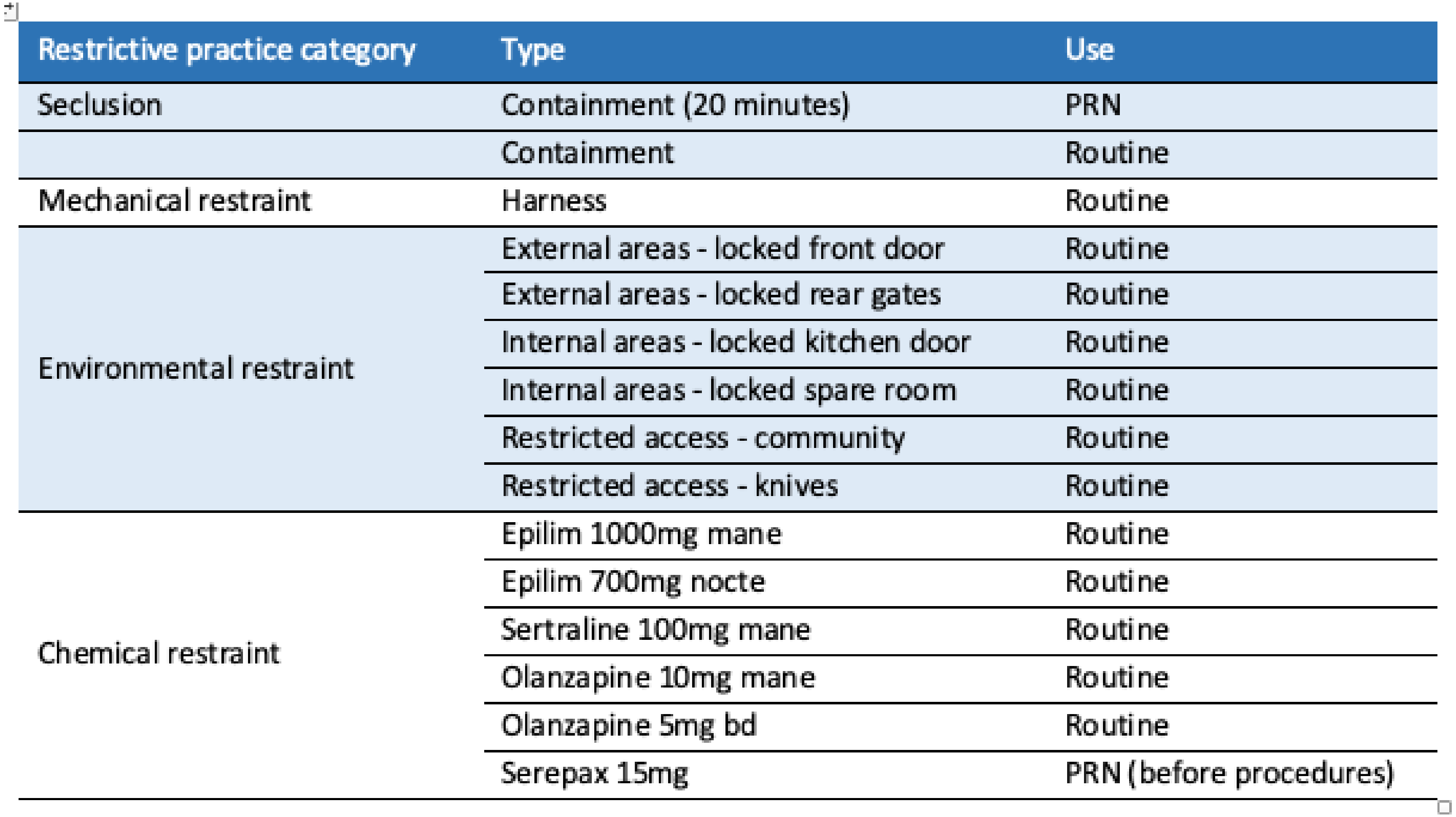
An empathetic and joy-based intervention

RUBIX SUPPORT
Specialised Assessment & Coordination

The scene

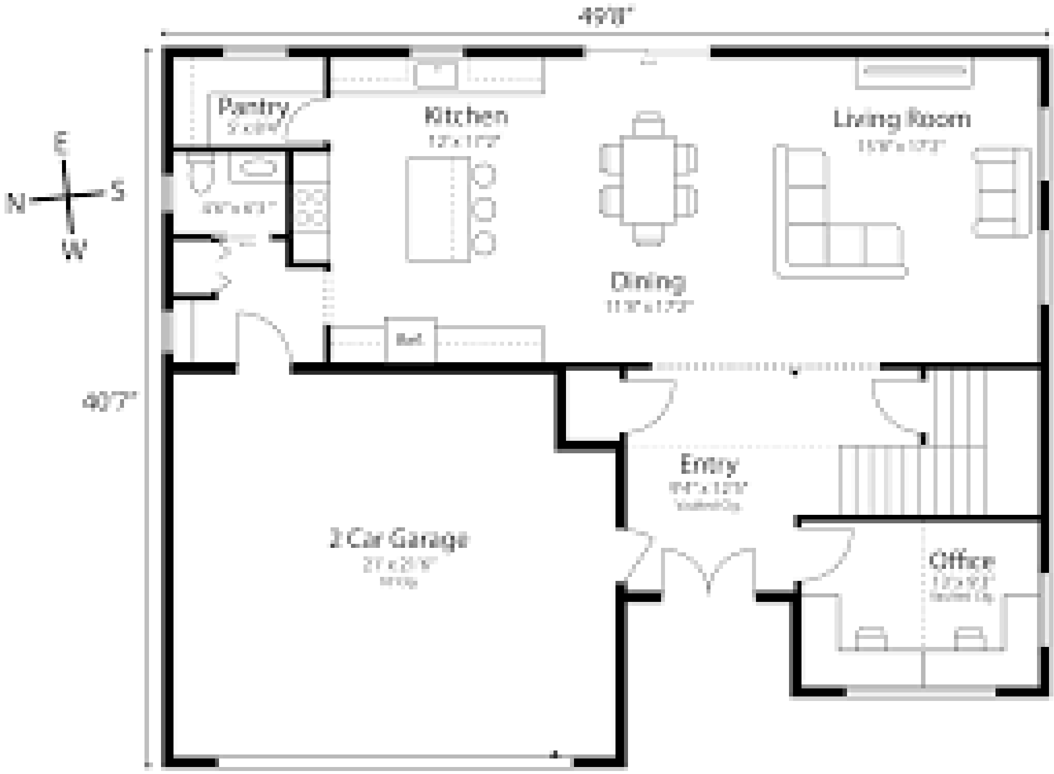
- 31-year-old man
- Non-speaking
- Autism
- Trauma survivor
- Living alone since 2013 in response to behaviours of concern within an SDA environment
- Absence of quality of life

Restrictive practices prior to October 2023



Restrictive practice category	Type	Use
Seclusion	Containment (20 minutes)	PRN
	Containment	Routine
Mechanical restraint	Harness	Routine
Environmental restraint	External areas - locked front door	Routine
	External areas - locked rear gates	Routine
	Internal areas - locked kitchen door	Routine
	Internal areas - locked spare room	Routine
	Restricted access - community	Routine
	Restricted access - knives	Routine
Chemical restraint	Epilim 1000mg mane	Routine
	Epilim 700mg nocte	Routine
	Sertraline 100mg mane	Routine
	Olanzapine 10mg mane	Routine
	Olanzapine 5mg bd	Routine
	Serepax 15mg	PRN (before procedures)

Restrictive access



Intervention guidelines

- An emphasis on introducing Dave as just a man with autism
- Sadness was a contributing variable and maintainer
- Positive change would be distressing
- Guided but not dictated by risk assessment (HCR-20V3)
- Elements of unfunded investment
- Recruitment based on Dave’s needs and risk profile
- Quality of life was the foundation to reducing restrictive practices

Replacing maladaptive environments

- Eliminate routine restriction on kitchen access
- Remove Perspex barriers
- Vehicle harness removed
- Identify safe community sites
- Engagement with CDDHV to guide chemical reductions
- Sexual needs assessment

Speed bumps

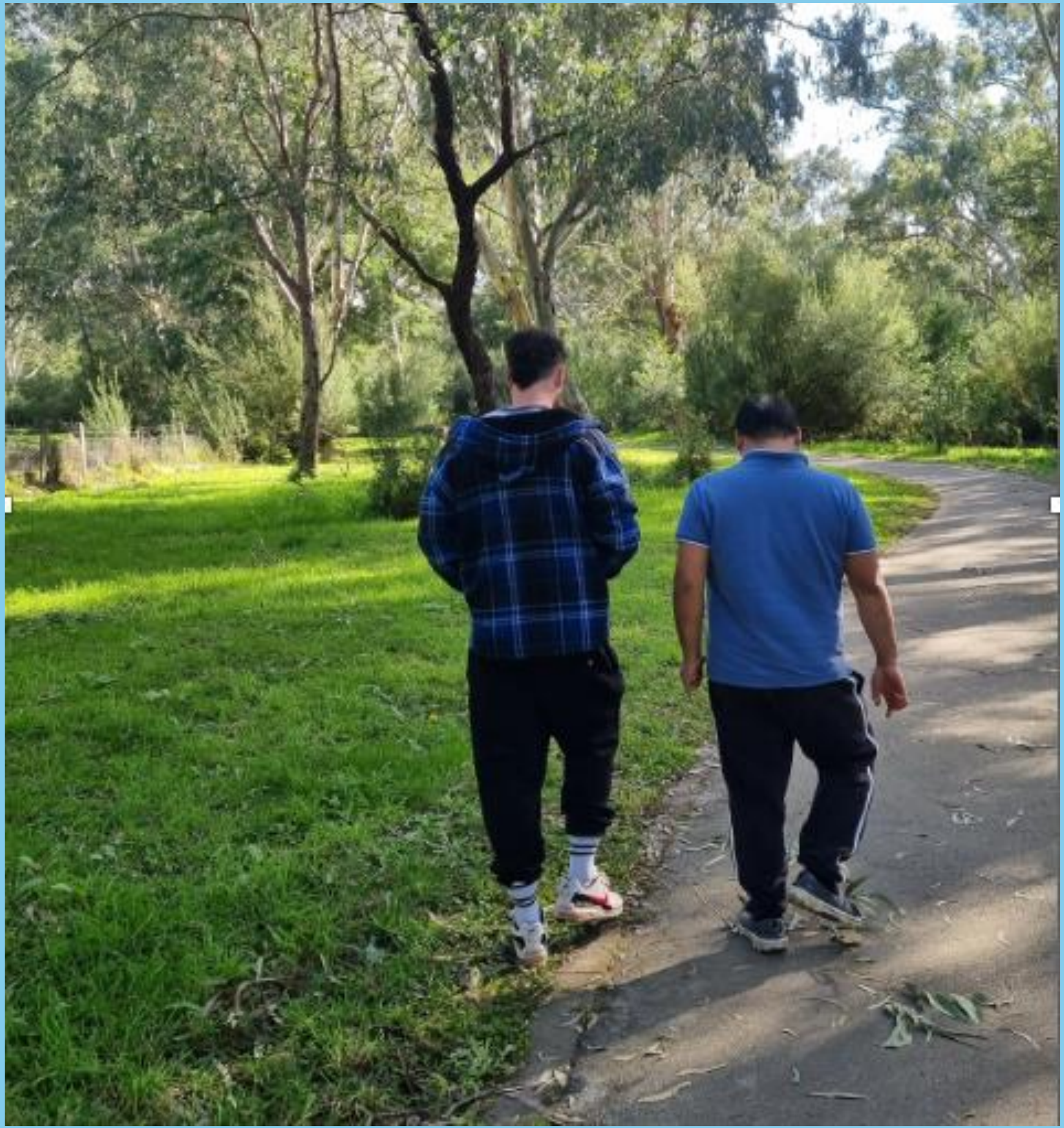
- Enthusiasm and drive for change
- Unpleasant effects of antipsychotic withdrawal

6 March 2024

First day on community soil

Touch

Connecting



Winning

Cooking

Seen

Current restrictive practices November 2024

Restrictive practice category	Type	Use
Seclusion	Maximum 20 minutes	PRN only
Environmental restraint	External areas - locked front door	Routine
	External areas - locked rear gates	Routine
Chemical restraint	Epilim 1000mg mane	Routine
	Epilim 700mg nocte	Routine
	Sertraline 100mg mane	Routine
	Olanzapine 5mg bd	Routine

Reductions in restrictive practices

53% reduction in restrictive practices

86% reduction in PRN seclusion

What did Dave teach us?

Quality of life and opportunities to feel joy is the fabric that underpins a successful intervention

A person's historical risk narrative can impede progress

Reframing the person through a lens of empathy and kindness promotes sustainability of supports and staff retainment

Change can only occur at a pace in which the person understands. Be prepared to go slower or even backwards

Behaviour change is a side hustle to the bigger picture

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UNBOUND – Showcase of artwork by artists with disability
10 – 23 February 2025

Thank you

Families, Fairness and Housing