

Home Modifications and behaviours of concern

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Please note:

The research and literature reviews collated by our TAB Tactical Research Team (TRT) are not to be shared external to the Branch. These are for internal TAB use only and are intended to assist our advisors with their reasonable and necessary advice provision.

Delegates have access to a wide variety of comprehensive guidance material. If Delegates require further information on access or planning matters, they are to call the TAPS line for advice.

TRT are unable to ensure that the information listed below provides an accurate & up-to-date snapshot of these matters.

Research question: What is the research evidence to support the effectiveness of home modifications for both adults and children with behaviours of concern?

Is there any research that relates to sensory processing/ leisure/interest activities to decrease BoC / increase independence (e.g., bathtubs, playgrounds, secure backyards)?

Date: 10/03/2023

Requestor: Helen s47F - personal privacy

Endorsed by: Melinda s47F - personal privacy

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2. Summary

Most reviews of the literature suggest some positive association between rates of behaviours of concern and features of the built environment while acknowledging the low quality of the evidence. There is low- to moderate- quality evidence of the association between fewer behaviours and improved air quality, accessibility, access to nature, and homeliness of the environment. Design features of a home may contribute to a reduction in stress and negative emotions, and to a reduction in resulting behaviours. To the extent that a home modification improves one of these design features, it is possible that a home modification may contribute to a reduction in behaviours of concern. However, it is difficult to draw causal conclusions due to the quality and study designs of the reviewed papers.

Guidelines regarding managing behaviours of concern generally recommend a personalised approach. This should involve analysing an individual's environment to isolate what factors are contributing to behaviours of concern. This often depends on the resident's preferences and sensory needs. If certain features of the built environment are found to contribute to behaviours of a particular person, removing or changing those features should be a part of the relevant behaviour support plan. This is required by *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018*. In some cases, changing features of a home which trigger behaviours of concern may involve home modifications.

Generalising about the effectiveness of particular modifications is not possible due to the current quality of the evidence and to the essentially individual nature of causes of behaviours of concern.

3. Quality of research

Features of the physical environment can affect our health and functioning in daily activities. Poor classroom acoustics can interrupt learning and academic performance (Murgia et al, 2023). Optimal temperature and ventilation can improve patient's health outcomes in hospitals (Shajaran et al, 2019). Researchers have tried to establish the link between built environment and mood. For example, neighbourhoods which encourage walkability may lead to improved health and mood of residents due to higher rates of physical activity (Han et al, 2022; Nuñez-Gonzalez et al, 2020). There is some evidence that heat and humidity increase arousal, while natural and green spaces decrease arousal (Baird et al, 2023).

It has been difficult to establish high quality evidence for direct association between specific features of the built environment and incidence of behaviours of concern. Of particular note, poor quality living environments are associated with low socio-economic conditions, which are independently associated with poor mental health (Tibber et al, 2022). Background economic conditions may often be the causal factor when studies do show a link between the built environment and poor mental health outcomes or high rates of behaviours of concern.

The available evidence is often of low quality and there are several gaps in the literature. Nine of the 11 systematic reviews reviewed by Nuñez-Gonzalez et al (2020) were found to be of critically low quality. Bridge and Vasilacopolou (2019) noted expert opinion was the highest frequency type of study appearing in the literature. Also, much of their evidence based is over 20 years old.

Baird et al (2023) note there is a particular lack of research on the impact of the physical environment on children with developmental disabilities. This is echoed by Roos et al (2022) who reviewed 276 studies but found little research on the effect of the built environment on people with intellectual disabilities in long-term care. They identified 26 components of the built environment that may affect health, behaviour and quality of life of people with intellectual disability but found research on only seven components. Two studies from Bridge and Vasilacopolou (2019) and Aljunaidy et al (2021) both note that there is an over-representation of research focussed on people with dementia and Alzheimer's disease compared to other developmental or psychiatric diagnoses. Almost 60% of the studies reviewed by Bridge and Vasilacopolou (2019) concerned dementia or Alzheimer's disease. The next most prevalent cohort in their study was intellectual disability at 18%.

4. Built environment and mental health

Qualitative studies show people associate features of the built environment with fluctuations in their mental health, including location, personal space, homeliness and security (Tekin et al, 2023; Rollings & Bollo, 2021):

Behaviours of concern can be the result of interaction between a person and the environment, wherein factors such as noise levels, stimulation or lack of stimulation,

unmet needs, or unpredictable environments can increase the risk of, and can be the motivation behind, such behaviours (Iffland et al, 2021, p.4).

There is a consensus that environmental features affect behaviours even if experimental and quantitative evidence cannot establish a direct causal link between particular environmental features and the rate of behaviours of concern in general.

Núñez-Gonzalez et al (2020) found two high quality systematic reviews investigating the effects of the built environment on mental health. Neither study found sufficient evidence to draw conclusions on the association between the built environment and mental health and neither discussed the presence of behaviours of concern (Moore et al, 2018; Turley et al, 2013). The only low risk of bias randomised controlled trial identified by Moore et al (2018) showed no effect between the built environment changes and mental health.

Some large-scale primary studies have showed an association between indoor environment and mental health. However, due to their study designs it is not possible to establish a causal link between indoor environments and mental health. A 2020 cohort study of 2290 children found poor indoor air quality caused by smoking leads to increased stress in younger adolescents (Franklin et al, 2020). The higher stress levels may be partially reduced by availability of green spaces. Exposure to second-hand smoke is also associated with more stressful living conditions for children and so it is not clear whether poor indoor air quality is the primary driver for increased stress levels. A survey of 8,177 people during COVID related lockdowns found a strong association between self-reported symptoms of depression and anxiety and lack of natural lighting, temperature control, air quality privacy, adequate space, good views, access to nature, quality acoustics, and homeliness (Amerio et al, 2020). This survey was based on self-reported measures and so it's not clear whether poor environmental features lead to poor mental health or whether people with poor mental health are more likely to feel negatively towards their living environment.

5. Built environment and behaviours of concern

Murgia et al (2023) suggests that poor classroom acoustics can lead to increased negative behaviours in children, including lack of attention and disruptive behaviour. However, the evidence for this link is assumed rather than directly established.

In their rapid review, Oostermeijer et al (2021) found evidence that restrictive practices could be reduced in psychiatric facilities with the introduction of access to private spaces, gardens, pools, and other amenities. This is supported in a later study from Harpøth et al (2022). The authors report reduction in restrictive practices after moving a psychiatric ward to a purpose-built facility prioritising privacy, outdoor spaces, airflow and access to amenities and activities. However, both studies note the difficulty of making causal inferences based on naturalistic experiments.

Baird et al (2023) found evidence connecting interior design and architectural features to aggressive behaviours and conduct problems in children. Low-moderate quality evidence

showed higher rates of behaviours of concern in children are associated with red painted rooms in the home, overcrowding and damp. In addition, they found inconsistent evidence that environmental noise such as air and road traffic and construction noise contribute to an increase in aggression. The authors hypothesised that noise may not cause aggressive behaviours but may exacerbate behaviours in those more sensitive to noise. Five of the six studies reviewed showed high or unclear risk of bias. The only study rated as low risk of bias was also authored by Baird et al.

Baird et al (2023) found some low-quality evidence connecting design and architectural features of playrooms with aggressive behaviours and conduct problems in children. An open playroom reportedly reduced aggressive behaviours but there were inconsistent results regarding the density of playrooms and no effect was observed for space per child or room size.

There is some inconsistent evidence for the benefit of greenspace and access to nature for young people, with the evidence broadly coalescing around positive effects on mood and behaviour (Baird et al, 2023; Tekin et al, 2023; Han et al, 2022; McIntosh et al, 2022).

5.1 Built environment and positive behaviour support

Recent studies which address environmental antecedents of behaviours of concern from a positive behaviour support perspective often focus on social and situational contexts (e.g., routine, activities, staff training, etc.) rather than physical features of the built environment (Konstantinidou et al, 2023; Mahon et al, 2022; Deb et al, 2022; Beqiraj et al, 2022; Bruisma et al, 2020). According to Caspar et al (2018), there is only minimal evidence that addressing physical features of the environment alone is sufficient to reduce behaviours of concern. They note that the evidence is more robust for interventions which treat physical and social environments and other psychological factors. However, due to the combined nature of these interventions it is often difficult to determine the causal factor.

Guidelines for developing individualised positive behaviour support plans suggest plans should include an analysis of possible environmental triggers for behaviours of concern with the aim of removing triggers to prevent behaviours. Significant environmental features related to the built environment can include:

- location (room, own or other's home, medical facility, school, new or unfamiliar locations, recent changes to the house or care setting)
- dimensions of the room (crowded, cramped, open, empty etc.)
- furniture (size, texture, materials, colour, too much/too little)
- walls and surfaces (material, density, fragility, angle, texture, colour)
- air temperature and quality, airflow, smells
- nature, plants and outdoor spaces (accessible, open, healthy etc.)
- acoustics and noise (creaking doors, rattling pipes, flapping blinds)

- light (brightness, colour, natural or artificial lighting)
- doors, windows, fences or other barriers (locks, latches, easily opened or closed)
- fixtures (access to taps, water temperature)
- homeliness or personalisation
- other features which may have specific associations for the person showing behaviours of concern (Roos et al, 2022; Limbu et al, 2021; DHHS, 2020; DHHS, 2019; Bridge and Vasilacopolou, 2019; DHHS, 2018; NICE, 2015).

The Victorian State Government's Department of Health and Human Services (now Department of Families, Fairness and Housing) recommends behaviour support practitioners consider the following questions about the physical environment:

- Does the physical environment allow the person to move around freely and gain assistance from others when needed?
- Does the physical environment reflect the person's likes and sensory preferences?
- Does the physical environment encourage independence and choice in daily activities? (DHHS, 2019, p.6)

Positive behaviour support plans should also include recommendations for environmental changes that may prevent behaviours of concern from developing. The *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* describe the conditions under which a behaviour support plan containing restrictive practice must be developed. Section 20.3(c) states that a specialised behaviour support practitioner must take reasonable steps to, "make changes within the environment of the person with disability that may reduce or remove the need for the use of regulated restrictive practices".

In cases where restrictive practice is unavoidable, the practice can be made possible or constituted by features of the home or physical environment. Time-outs, seclusion and secure spaces for staff require adequate space, fixtures and security features to enact. Restrictive practices can also include locks on doors or cupboards, surveillance technology or other structural features which prevent a person from accessing activities or areas in their home (NDIS Quality and Safeguards Commission, 2022; NDIS Quality and Safeguards Commission, 2020; Bridge and Vasilacopolou, 2019).

Table 1 below shows some examples of housing design features which may help to prevent or manage behaviours of concern. The list is adapted from Bridge and Vasilacopolou (2019). These suggestions are derived from a small sample of recommendations in the literature and are not exhaustive.

Feature	Example
Light	- Assess visual and light sensitivities and personalise type and level of light where possible. - Avoid shiny floors and polished furniture. - Install curtains to reduce glare. - Install adjustable lighting (e.g., dimmer switches) and maintain consistency. - Avoid flickering lights. - Reduce light level at night.
Temperature	- Maintain comfortable temperature and humidity. - Ensure temperature is adjustable.
Air Quality	- Remove unpleasant smells. - Ensure adequate ventilation or air flow.
Use of space	- Make spaces as accessible as possible. - Install features that are removable, adjustable or able to be de-activated easily. - Install lockable doors and windows. - Consider whether automatic or remote-controlled fixtures are appropriate. - Create spaces that allow the resident to control sensory stimulation.
Appearance	- Safety and protective features should be subtle to avoid an institutional feel. - Install appropriate signs and other visual information. - Ensure spaces are personalisable and homely. - Remove elements which may be overstimulating (clutter, alarms). - Use materials that are durable and easily washable.
Noise	- Select quiet appliances or place noisy appliances away from bedrooms and main living areas. - Hang art or other aesthetically pleasing wall coverings to reduce reverberation.

Table 1 Housing design features to address behaviours of concern (Bridge and Vasilacopolou, 2019)

5.2 Autonomy and homeliness

There is a theme throughout the literature that a person's feeling of control over their environment mediates incidence of behaviours of concern. Deb et al (2022) quotes care staff

describing triggers in the physical environment such as the colour of a room or the position of curtains. To address environmental triggers, many studies recommend strategies centred around resident's choice and control, such as access, privacy, predictability, personalisation, adjustability, customisability and homeliness (Baird et al, 2023; Haig and Hallet, 2022; Oostermeijer et al, 2021; Iffland et al, 2021; Bridge and Vasilacopolou, 2019).

Roos et al (2022) found evidence of association of behaviours of concern with the type of residential facility, its size and homeliness, available views and sound quality/acoustics. The authors suggest that most variables show effects based on their contribution to the homeliness of the environment and access to appropriately stimulating activities and environments. Homeliness has a positive association with behaviours including less lethargy, less hyperactivity and less aggression, increased participation in social, domestic and individual activities. Homeliness can be achieved in an institutional setting with:

smaller wards, rooms of different sizes with windows of different sizes and in different places, public (common) spaces closer to the front door, unique bedrooms, wooden doors, wallpaper, carpet, art, less reverberation, more light points in the living room, and personal objects in the room (Roos et al, 2022, p.308).

These environments are likely to be more appropriately stimulating as well. In contrast, a place is felt to be more institutional when it has:

more office, less public space, the same bedrooms, wide hallways, large rooms, high ceilings, more passageways, rough (stone) walls, vinyl floors, little lighting, fixed ceiling lights, more fire alarm systems, bare walls, different chairs, rows of toilets and sinks, paper towel dispensers, grab bars, and more adaptations to disabilities ... the roof is less visible from the street, the driveway is longer, there are more windows in the facade, and there is less greenery around the building (Roos et al, 2022, p.308).

However, as the authors did not perform a meta-analysis or investigate the quality, level of evidence or risk of bias of the included studies, the evidence they present should be treated as of very low quality.

5.3 Multi-sensory environments

Multi-sensory environments (MSEs; also called comfort rooms, sensory rooms or Snoezelen rooms) are rooms designed to provide an ideal sensory environment with the aim of soothing or stimulating a person with specific sensory needs (Unwin et al, 2022; Cameron et al, 2020). MSEs have been used in nursing homes, schools, hospitals and psychiatric facilities. Little research on MSEs have looked into their use in home environments (Unwin et al, 2022; Backman et al, 2021; Cameron et al, 2020; Bridge and Vasilacopolou, 2019).

TRT's [RES 276 Sensory-based therapies](#) provides more detail on MSEs and their effect on the use of restrictive practice.

Evidence for the effectiveness of MSEs is generally of low quality due to study designs, risk of bias, differences in how rooms are structured and used. Many studies also combine MSE use

with other interventions such as staff training in behaviour support (Unwin et al, 2022; Haig and Hallet, 2022; Oostermeijer et al, 2021).

In their 2022 review, Haig and Hallet did not find convincing evidence for a reduction in aggressive behaviours of concern, though evidence does suggest that MSEs can provide comfort to users in psychiatric facilities. The reviewed studies unanimously showed a reduction in subjective measures of distress and a few studies also showed a reduction in arousal, anxiety, irritability, hostility and withdrawal. Reduction in negative emotional states may lead to a reduction in associated behaviours of concern, though the evidence for this connection is less established (Oostermeijer et al, 2021; Cameron et al, 2020). Backman et al (2021) reviewed three studies using MSEs in residential facilities for older people and found more equivocal evidence for benefit to emotional well-being and mental health.

There is some evidence that the way the room is used can mediate its effectiveness. Haig and Hallett (2022) note that distress increased for a small number of patients, which may relate to the different ways in which MSEs are set up and used and different sensory needs of individuals. Unwin et al (2022) found that children with autism who were able to control features of the room's equipment (active condition) showed increase in attention and reduction in repetitive motor and sensory behaviours. It is important to note that these behaviours are not necessarily concerning and a decrease in sensory and repetitive behaviours may not have any relation to the person's health or well-being. The authors also found no significant difference in social behaviours, anxiety, positive affect or arousal between the active and passive conditions.

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Applied Behaviour Analysis for adults with ASD

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Please note:

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The Research Team are unable to ensure that the information listed below provides an accurate & up-to-date snapshot of these matters

Research question: Is there any research evidence that ABA therapy is effective in the treatment of ASD in adults?

Date: 14/2/2022

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2. Summary

There is evidence that interventions based on Applied Behaviour Analysis (ABA) can be effective in improving skills and outcomes and reducing concerning behaviour for older adolescents and young adults with autism. However, the evidence base is small and the literature mostly reports on single subject case studies or otherwise small sample studies.

There is a lack of consensus about effective and ethical intensity of behavioural interventions. ABA is a discipline which incorporates many different techniques and treatment protocols. It is possible that different ABA interventions would require different frequency and duration of supports. No studies were found that focussed on intensive ABA for older teenagers or adults.

The focus of this paper is on recent published research which summarises and reviews existing research. Considering the timeframe of this paper and the breadth of literature, it should be noted that there may be further relevant research we have not examined.

3. Evidence for ABA in adults

Research on interventions for older adolescents and young adults with autism is scarce. Most of the research on ABA focusses on younger children. Results of research on younger children may not generalise for adults (Shattuck et al, 2020; Howlin, 2021; Lord et al, 2022; Rodriguez et al, 2022). Straiton et al (2021) conducted a survey study including 97 ABA providers that related to parent training as a component of ABA practice for people with autism under 21. They note that very few ABA providers were aware of evidence-based strategies for incorporating parent training in their program. Lord et al (2022) summarise the evidence:

Behavioural programmes for adults with autism have been described for many years, although few are randomised controlled trials and many involve individuals with more severe intellectual disabilities. The use of behavioural approaches is also controversial among some neurodiversity advocates (Lord et al, 2022, p.290).

Much of the research on autism in adulthood focusses on life-stage outcomes rather than specific interventions (Mason et al, 2021; Howlin, 2021). Much of the research on use of behavioural interventions in adults with autism focusses on ethical issues and describes the controversy around long term use of ABA (Sandoval-Norton et al, 2019; Gorycki et al, 2020; Shkedy et al 2021).

Evidence-based behavioural interventions identified by Steinbrenner et al (2020) for 15-22 year olds include antecedent-based interventions, behavioural momentum intervention, differential reinforcement, discrete trial training, extinction, functional behavioural assessment, modelling, prompting, reinforcement, response interruption/reintegration, self-management, task analysis, video modelling, and visual supports. These interventions may make up an ABA program. It is worth noting that, for Steinbrenner et al, an intervention counts as evidence-based if it has support from either:

- two high quality group design studies conducted by at least two different researchers or research groups
- five high quality single case design studies conducted by three different investigators or research groups and having a total of at least 20 participants across studies
- one high quality group design study and at least three high quality single case design studies conducted by at least two different investigators or research groups.

This approach to evidence-based practice is challenged in the literature (Donovan et al, 2020; Lord et al, 2022). For instance, the Steinbrenner et al approach means that some practices may count as evidence-based even if they have only a small number of uncontrolled studies supporting them and even if very few subjects were involved in the intervention.

In their narrative review, Rodriguez et al (2022) provide more detail about some behavioural interventions they consider efficacious for adults. These include self-management, prompting, video modelling, visual supports, task analysis, behavioural skills training, and functional communication training. The authors note that for all these interventions there is minimal adult focussed research. Where evidence for efficacy in adult populations exists, it is usually based on single subject case studies or other small sample study designs. One recent systematic review found moderate to strong evidence that functional communication training can reduce challenging behaviours in adults with autism (Gregori et al, 2020). However, this was based on only 8 participants across 8 single case studies. Another recent study found behavioural skills training improved social and conversation skills for 6 adults with autism when delivered in a group setting (Ryan et al, 2019).

Theoretically, many of the principles of ABA should work for all age groups. For example, reinforcement may encourage target behaviour regardless of age group. However, effect size may be different and different skill areas may be targeted (e.g. community independence, vocational training) for older adults, young adults and adolescents. Also, there may be some issues of implementation. For example, Rodriguez et al (2020) note that removing reinforcement of undesirable behaviours can result in increases in aggression for up to 50% of subjects. For adults with aggressive behaviours this can pose a significant safety risk (Manente et al, 2010).

4. Duration and intensity of behavioural intervention

There is a lack of consensus on the appropriate intensity and duration of behavioural interventions. Gerhardt et al (2022) suggest it is a myth that adolescents and young adults would no longer benefit from intensive ABA. However, while the authors cite evidence showing ABA may be effective for adolescents and young adults, they do not provide evidence for a high intensity of support. With respect to early intensive behavioural intervention, Leaf et al (2022) state that intervention is usually concluded prior to school age, though if a child still requires support then intervention should continue into school age:

Although the average may be 3 years, research has shown that a successful duration can be anywhere between 6 and 36 months. Like the intensity of intervention, the duration of intervention must be individualized to meet the needs of the individual learner (Leaf et al, 2022, p.254).

In contrast, the recent *Lancet Commission on the future of care and clinical research in autism* report states that the intensive ABA approach:

as originally implemented, has little support from well-designed randomised controlled trials. However, it has been modified over the past few decades to be more naturalistic and developmentally appropriate, often with lower-intensity delivery and greater emphasis on the child as an active partner in communication. In addition, other studies have focused on teaching parents to support the child in the development of early communication and social interaction (Lord et al, 2022, pp.278-279).

Shkedy et al (2021) argue there is no research showing the effectiveness of ABA for people who have received treatment over 5, 10 or 15 years (also, Donovan et al, 2020). While the appropriate intensity and duration of support is in dispute, Lord et al maintain there is evidence that behavioural intervention can improve cognitive and emotional self-regulation and reduction in social difficulties for older children and young adults. They continue:

As for other chronic and enduring health conditions, one-off, time-limited interventions will not be sufficient to enable long-term change for most people with autism. Instead, a developmentally sequenced series of staged and personalised interventions will be required for each individual, according to their developmental stage, profile of strengths and needs, and co-occurring conditions (Lord et al, 2022, pp.279-280).

The recommendation for a 'staged' service implies that the least intensive service is trialled to determine what the participant's needs are.

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Applied behaviour analysis and positive behaviour support

The content of this document is OFFICIAL.

Please note:

The research and literature reviews collated by our TAB Research Team are not to be shared external to the Branch. These are for internal TAB use only and are intended to assist our advisors with their reasonable and necessary decision-making.

Delegates have access to a wide variety of comprehensive guidance material. If

Delegates require further information on access or planning matters, they are to call the TAPS line for advice.

The Research Team are unable to ensure that the information listed below provides an accurate & up-to-date snapshot of these matters

Research question: What is the difference between Applied Behaviour Analysis and positive behaviour support? Is intensive ABA effective for managing behaviours of concern? What qualifications and legislative requirements are required for a practitioner to develop or implement a positive behaviour support programme?

Date: 21/07/2022

Requestor: Kim s47F - personal

Endorsed by (EL1 or above): Naomi s47F - personal privacy

Researcher: Aaron s47F - personal privacy

Cleared by: Shane s47F - personal p

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2. Summary

There is ambiguity in the way Applied Behaviour Analysis (ABA) and Positive Behaviour Support (PBS) are used to describe interventions or disciplines. ABA as a label can be used in wider or more narrow ways and depending on how the term is used it might encompass PBS as well. In the sense employed in much NDIS documentation, PBS is theoretically informed by ABA as an applied research program, while being distinguished from ABA as a specific intervention or therapy programme.

There is moderate level evidence that intensive ABA programs reduce behaviours of concern. However, no information on dosage was found.

While there are some intensive ABA programmes that can only be run by Board Certified Behaviour Analysts, some ABA-informed programs can be run by qualified health professionals (e.g Occupational Therapists, Speech Therapists) for which the programme is within their scope of practice. Positive behaviour support practitioners require specific registration through the NDIS Quality and Safeguards Commission in order to provide behavioural assessments and behaviour support plans for NDIS participants. However, I cannot find any evidence that “behaviour support practitioner” or “positive behaviour support practitioner” are regulated terms outside of their use in the context of NDIS registered providers.

3. Applied behaviour analysis

The definition of ABA used in the NDIA commissioned AutismCRC report *Interventions for children on the autism spectrum: A synthesis of research evidence* is:

the scientific application of behavioural principles to, first, identify variables that are responsible for behavioural change, and second, to use these variables to improve socially significant behaviours (Whitehouse et al., 2020, p.31).

This definition is derived from Cooper et al (2020), who say:

Applied behaviour analysis is the science in which tactics derived from the principles of behaviour are applied systematically to improve socially significant behaviour and experimentation is used to identify the variables responsible for behaviour change (Cooper et al., 2020, p.19).

As both these definitions show, the practice of ABA is intended to improve socially significant behaviours. This is a very broad category of behaviours that can include:

social, language, academic, daily living, self-care, vocational, and/or recreation and leisure behaviours that improve the day-to-day life experience of the participants and/or affect their significant others (parents, teachers, peers, employers) in such a way that they behave more positively with and toward the participant (Cooper et al., 2020, p.16).

For reasons of terminological clarity, we should also note that ABA is used by Cooper et al to refer to an applied research program. Cooper et al (2020) distinguish between ABA as a research discipline on the one hand, and on the other, professional practice in which insights from ABA are integrated into frontline services for use by participants, family, teachers or trained therapists. Whitehouse et al. (2020) use ABA to refer to both the applied research program and its application by Board Certified Behaviour Analysts. They distinguish ABA as applied by Board Certified Behaviour Analysts from derivative forms of behavioural intervention which might depend on ABA principles but diverge in some way. They cite, for example, Naturalistic Development Behavioural Interventions, Picture Exchange Communication System, Early Start Denver Model and Positive Behaviour Support. Rogers et al list interventions they consider a kind of intensive ABA-type therapy, including Murdoch Early Intervention Program, Early intensive behavioural intervention, Early start denver model, Comprehensive intensive early intervention and Intensive behaviour analytic treatment (Rogers et al, 2020).

4. Positive behaviour support

The NDIS Quality and Safeguard Commission Positive Behaviour Support Capability Framework defines PBS as:

the integration of the contemporary ideology of disability service provision with the clinical framework of applied behaviour analysis. Positive behaviour supports are supported by evidence encompassing strategies and methods that aim to increase the person's quality of life and reduce challenging behaviour (NDIS Quality and Safeguards Commission, 2019, p.5).

The idea that PBS is ABA plus “the contemporary ideology of disability” refers to Carr et al.'s suggestion that PBS emerged from three sources including ABA, the normalisation/inclusion movement and person-centred values (Carr et al, 2002). There is some question about whether PBS is a kind of ABA, or just informed or otherwise related to it (Whitehouse et al, 2020). It is also not clear what the practical implications of this question are.

Like ABA, PBS focusses on socially significant behaviours though its target behaviours are restricted to challenging or problematic behaviours. There is no agreed terminology used to describe challenging or problematic behaviours. Synonyms used include: behaviours of concern, challenging behaviour, behaviour that challenges, maladaptive behaviour, interfering behaviour, disruptive behaviour, problem behaviour and problematic behaviour (Whitehouse et al, 2020; Rogers et al, 2020).

UK's National Autism Centre defines problem behaviours as behaviour that:

can harm the individual or others OR result in damage to objects OR interfere with the expected routines in the community. Problem behaviors may include but are not restricted to self-injury, aggression, disruption, destruction of property, or hazardous or sexually inappropriate behaviors (National Autism Centre, 2015, p.39).

UK's National Institute of Healthcare Excellence also considers stereotypic behaviour and withdrawal to be challenging behaviours (NICE, 2015). Whitehouse et al. use the definition:

Challenging behavior refers to certain behaviors that a person engages in which negatively affect his/her daily functioning. These behaviors are often recognized as being culturally abnormal and occur at such an intensity, frequency, or duration that the safety of the person and/or others is placed in jeopardy. Challenging behaviors may be related to social, academic, communicative, cognitive, vocational, or physical domains, may serve various functions, and should be examined systematically in order to identify these functions (Whitehouse et al, 2020, pp.122-123).

While PBS targets specific behaviours, strategies to address those behaviours take account of “a person’s needs, their home environment and overall quality of life through assessment, planning and intervention” ([Practice Guidance – Behaviour Support and Behaviours of Concern](#)). This relates to another core feature of PBS cited by the NDIS commission: PBS aims to reduce and eliminate restrictive practice ([NDIS Quality and Safeguards Commission](#), 2022, Glossary).

5. Intensive Applied Behaviour Analysis and behaviours of concern

Whitehouse et al. (2020) summarise evidence from systematic reviews which track the effect of behavioural techniques on challenging behaviours. In three systematic reviews including a variety of behavioural interventions, they note a moderate level of evidence indicating a positive effect on challenging behaviours. Regarding specific interventions, they note that there is low level evidence that Functional Communication Training and Discrete Trial training have a positive effect on challenging behaviours and moderate level of evidence that Early intensive behavioural intervention has a null effect on challenging behaviours.

The UK's National Autism Centre report (2015) notes that behavioural interventions can reduce problem behaviours for people aged 3 – 22 years old. More specifically, ABA type programs delivered 25-40 hours per week for 2-3 years are shown to reduce problem behaviours for children aged 0 – 9. More recently, a team from the US-based National Clearinghouse on Autism Evidence and Practice found Functional Communication Training – an off-shoot of ABA – has a positive effect on reducing behaviours of concern for children 3 – 18 years. They also found Discrete Trial Training – another ABA off-shoot – can be effective at reducing behaviours of concern in children aged 6 – 11 years (Steinbrenner et al, 2020).

However, due to the layout of both the National Autism Centre report and the Clearinghouse on Autism Evidence and Practice report, it is not clear from which studies they derived the confident assessment that ABA-type therapies can reduce problem behaviours. This is important as other reviews make more tentative claims. Rogers et al (2020) reviewed 20 intensive ABA studies and found one noting reduction in behaviours of concern but results were not statistically significant. In their systematic review, Reichow et al (2018) considered 2 studies which tracked problem behaviours. They found very low-quality evidence that EBEI did not have a statistically significant difference effect at reducing behaviours of concern compared to therapy as usual control. However, given the growth of autism research in the last 5 years, currency is a problem for this review (Whitehouse et al, 2020).

This brief summary does show some evidence for effectiveness of ABA-type therapies in reducing behaviours of concern. There are some inconsistencies in results and the research could be of higher quality. It is also worth noting that none of the reviews spoke to the dosage required to effect a reduction in behaviours of concern. While 25-40 hours per week is noted as the dosage in the National Autism Centre report, it is not clear from the evidence reviewed that this level of therapy is required to achieve the outcomes stated or that other therapies derived from ABA have this level of implementation.

Also of note, there is evidence that other types of therapies are also effective at reducing behaviours of concern. For example, of 28 evidence-based practices that Steinbrenner et al consider, only 2 did not show some effect at reducing behaviours of concern for some age group of children or young adults.

Reichow et al conclude their review by saying:

Given the lack of high-quality, generalizable evidence to determine the effects of Early Intensive Behavioural Intervention (EIBI) for ASD, it is important that decisions about its use are made on a case-by-case basis. It is also important that providers of EIBI are aware of the limited quality of the current evidence and use clinical decision-making guidelines, such as seeking the family's input and drawing upon prior clinical experience, when making recommendations to clients on the use of EIBI (Reichow et al, 2018, p.17).

6. Practitioner qualifications and registration requirements

6.1 Board Certified Behaviour Analysts

ABA practitioners should be qualified, regulated and deliver services that are within the scope of their clinical practice. Unlike other allied health professionals in Australia, ABA practitioners are currently accredited internationally by the Behavior Analyst Certification Board (BACB) based in USA (Whitehouse et al, 2020; Association for Behaviour Analysis Australia, n.d).

BACB provide certification for:

- Registered Behavior Technician (RBT) – works under supervision of BCaBA and BACB
- Board Certified Assistant Behavior Analyst (BCaBA) – works under supervision of BACB
- Board Certified Behavior Analyst (BCBA) – works independently and can supervise RBT and BCaBA (Behaviour Analysis Certification Board, n.d, [Board Certified Behavior Analyst](#)).

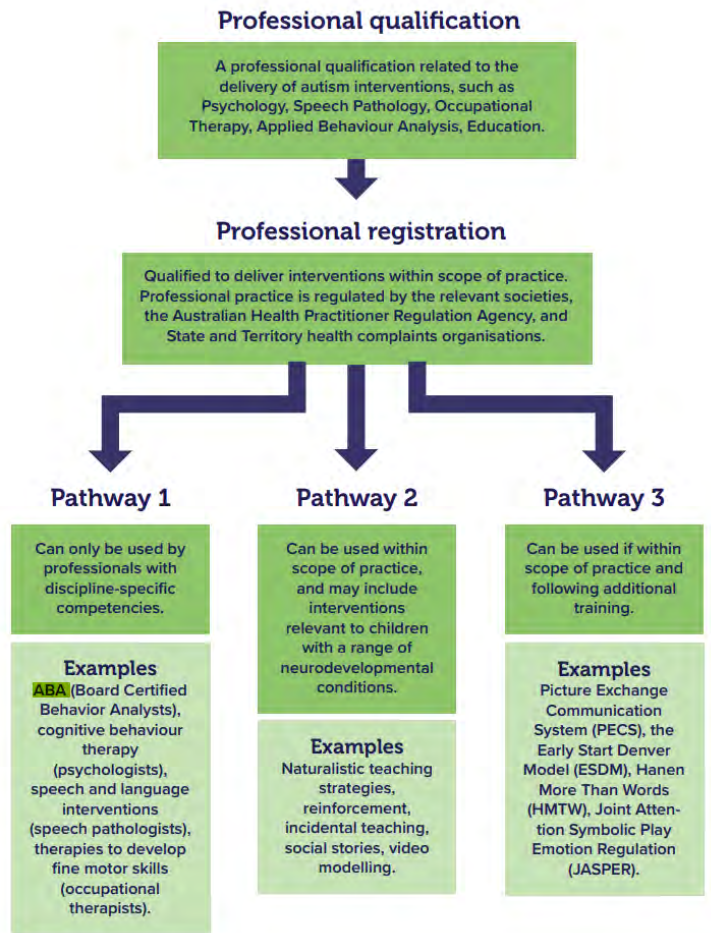
To gain and maintain accreditation as a BACB, a practitioner needs to:

- complete a recognised course or equivalent professional experience
- pass an exam
- meet continuing education requirements
- adhere to ethics requirements
- recertify every 2 years (Behaviour Analysis Certification Board, n.d, [Credentials](#)).

Association for Behaviour Analysis Australia has expressed their intention to take up regulation and accreditation of ABA practitioners in Australia:

As of December 2019 the BACB announced that it will limit certification to a select number of countries. Currently, Australia is one of the countries where BACB certification is still available but the longevity of this option is unknown. This has highlighted the need for Australia to have its own regulatory body for behaviour analysts. ABA Australia saw the need of our field and felt that it was inline with our mission and objectives to take on this challenge and continue our efforts to disseminate safe and ethical practice of ABA (Association for Behaviour Analysis Australia, n.d, [Professional Self-Regulation](#)).

Not all interventions which incorporate the principles or strategies of ABA are restricted to certified BCBAs. The figure below from Whitehouse et al (2020, p.47) describes different pathways by which ABA-type or associated interventions can be practiced.



6.2 Behaviour support and the NDIS

Specialist behaviour support is provided through a participant's NDIS plan through the Improved Relationships budget using line items:

- Specialist Behavioural Intervention Support
- Behaviour Management Plan Including Training in Behaviour Management Strategies

A registered specialist behaviour support practitioner must develop all functional behaviour assessments and Behaviour Support Plans, as positive behaviour support practice requires a specific skillset and appropriate safeguards ([Practice Guidance – Behaviour Support and Behaviours of Concern](#)). An NDIS behaviour support practitioner must be deemed suitable by the NDIS Quality and Safeguard Commission ([NDIS Restrictive Practices and Behaviour Support Rules 2018](#), s17). To be deemed suitable the practitioner must be qualified, experienced and must have considered their professional development alongside the [Positive Behaviour Support Capability Framework](#) (NDIS Quality and Safeguards Commission, 2022, [Fact sheet: New behaviour support practitioners](#)).

The above is required for a practitioner to provide positive behaviour support to NDIS participants. There may be qualified and practicing behaviour support practitioners who are not NDIS behaviour support practitioners. I cannot find any evidence that “behaviour support practitioner” or “positive behaviour support practitioner” are regulated terms outside of their use in the context of NDIS registered providers.

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8. Version control

Version	Amended by	Brief Description of Change	Status	Date
1.0	Aaron 547F - personal privacy	Research focussing on relationship between ABA and PBS	Draft	25/07/2022

Advice Support Tool

Theme: CB Relationships

Sub-Theme(s): Restrictive Practice

References:

[NDIS Act 2013](#) Section 34 1. (a) - (f) and 2.

[NDIS Support for Participant Rules 2013](#)

s47E(d) - certain operations of agencies

Restrictive Practices:

The NDIS Commission is taking the lead role in reducing and eliminating the use of restrictive practices and holds responsibility for monitoring the use of all restrictive practices recommended and implemented by NDIS providers in Australia. The NDIA is not responsible for making decisions about the use of restrictive practices. Under the NDIS (Restrictive Practices and Behaviour Support) Rules 2018, restrictive practices are subject to regulation. Restrictive practices can only be used based on an assessment of behaviour with the appropriate authorisation from the relevant state or territory and where it is part of a BSP that has been developed by a registered behaviour support specialist.

Behaviour Support:

Behaviour supports are to be provided in accordance with the NDIS Commission's requirements for positive behaviour support. The NDIS funds reasonable and necessary supports designed to identify and reduce BoC, to improve the participant's quality of life, uphold their dignity and safeguard their rights.

Note: All criteria need to be met for the supports to be funded through the NDIS.

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
34.1(a) Enabling the participant's goals and objectives (supports will assist the participant to pursue the goals and objectives in their plan)	☒ Yes → ☐ No →	s47E(d) - certain operations of agencies Where restrictive practice is being implemented, the legislative framework MUST be followed.
34.1(b) Assist the participant's social and economic participation (supports will assist the participant to undertake activities to facilitate their social and economic participation)	☒ Yes → ☐ No →	s47E(d) - certain operations of agencies
s47E(d) - certain operations of agencies Are there comparable support options which would achieve the same outcome at a substantially lower cost? What alternative supports were considered?	☒ Yes → ☐ No →	Note: where restrictive practice is identified, the NDIS Commission has highlighted to the Agency that there should be adequate funding made available for a Behaviour Support Practitioner to fulfil legislative requirements including the undertaking of a Functional Behavioural Assessment, development of interim and comprehensive BSP's, and training of informal and formal supports in strategies specific to the participant's support needs. s47E(d) - certain operations of agencies

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
s47E(d) - certain operations of agencies Is there evidence that funding support is likely to increase independence and reduce funded support costs in the long-term? Is there evidence the support will increase the participant's independence and reduce the participant's need for other kinds of supports? s47E(d) - certain operations of agencies Is there evidence the quoted support cost is comparable to expected cost of same kind of supports? s47E(d) - certain operations of agencies		s47E(d) - certain operations of agencies

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
		s47E(d) - certain operations of agencies
34.1(d) Support is effective or beneficial for the participant s47E(d) - certain operations of agencies How will effectiveness of achieved outcome be measured? When will effectiveness of achieved outcome be achieved? Are there other supports required to achieve or maximise the reported support outcomes for participant?	☒ Yes → ☐ No →	s47E(d) - certain operations of agencies

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
		s47E(d) - certain operations of agencies
34.1(e) Support coordinates with but does not replace informal support (funding or provision of supports takes account of what it is reasonable to expect families, carers, informal networks and the community to provide) Consider NDIS Support for Participant Rules 2013 Part 3.4	☒ Yes → ☐ No →	
34.1(f) Support is most appropriately funded by the NDIS (supports are not more appropriately funded or provided through other general service systems or universal service obligations) Consider NDIS Support for Participant Rules 2013 Schedule 1.	☒ Yes → ☐ No →	

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
		s47E(d) - certain operations of agencies

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
		s47E(d) - certain operations of agencies
Support will not cause harm (Supports will not be funded if it is likely to cause harm to the participant or pose a risk to others, or the support would be contrary to a law of a jurisdiction) Consider NDIS Support for Participant Rules 2013 Part 5.1 and 5.3	☒ Yes → ☐ No →	

Criteria for reasonable and necessary supports	Is criteria met?	Considerations (including evidence used)
		s47E(d) - certain operations of agencies
Support is directly related to the participant's disability s47E(d) - certain operations of agencies	☒ Yes → ☐ No →	
Support does not duplicate other supports s47E(d) - certain operations of agencies such as Information, Linkages and Capacity Building (ILC) funding.) s47E(d) - certain operations of agencies	☒ Yes → ☐ No →	
Are all of the above criteria met for all supports?	☒ Yes → ☐ No →	

Version Control

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Technical Advisory Branch (TAB)

Guide to Restrictive Practice Processes by Australian state and territory

Seclusion
Chemical
Mechanical
Physical
Environmental

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1. Purpose

This document is a guide concerning the entities responsible for the authorisation of regulated restrictive practices (RRP) and the authorisation in each of the Australian states and territories. The guide was developed to assist TAB Advisors who provide advice on behaviour supports and restrictive practices, and should be read in conjunction with:

- [National Disability Insurance Scheme Act 2013](#)
- [NDIS Quality and Safeguards Commission Positive Behaviour Support Capability Framework](#)
- [NDIS Quality and Safeguards Commission Regulated Restrictive Practices Guide](#)
- [NDIS Quality and Safeguards Commission Regulated Restrictive Practices with Children and Young People with Disability](#)
- [National Disability Insurance Scheme \(Restrictive Practices and Behaviour Support\) Rules 2018](#)
- [National Disability Insurance Scheme \(Provider Registration and Practice Standard\) Rules 2018](#)

2. Restrictive Practices

Restrictive practices are ‘any practice or intervention that restricts the rights or freedom of movement of a person with a disability’ (NDIS QSC, 2020). The *NDIS Restrictive Practices and Behaviour Support Rules 2018* state regulated restrictive practices (RRP) involve any of the following:

Regulated Restrictive Practices	Not Regulated Restrictive Practices
Seclusion: sole confinement in a room or physical space, any hour of day or night, where voluntary exit is prevented, not facilitated or implied it is not permitted (Australian Government, 2018a)	Seclusion is not: a person who chooses to have quiet time on their own in their room where they are able to come out at any time or someone choosing to lock their door for privacy, where they are able to unlock the door and exit whenever they choose to (NDIS QSC, 2020).
Chemical restraint: use of medication or chemical substance for the primary purpose of influencing behaviour (Australian Government, 2018a). This includes use of medication to achieve menstrual suppression without informed consent of the person and anti-libidinal medication to reduce sexual arousal and reduce problematic sexual behaviours (NDIS QSC, 2020).	Chemical restraint is not: medication prescribed by a medical practitioner for the treatment of diagnosed mental disorder, physical illness or physical condition (Australian Government, 2018a). e.g., medication given to a person to relieve anxiety to attend an appointment (NDIS QSC, 2020).
Mechanical restraint: use of a device to prevent, restrict or subdue movement for the primary purpose of influencing behaviour. e.g., use of a harness to help a person calm down.	Mechanical restraint is not: use of devices for therapeutic or non-behavioural purposes (Australian Government, 2018a). e.g., use of a harness for postural support.
Physical restraint: use or action of physical force to prevent, restrict or subdue movement of a person’s body, or part of their body, for the primary purpose of influencing their behaviour (Australian Government, 2018a).	Physical restraint is not: assisting a person with daily living activities to complete a task safely and who accepts this support, e.g., if the person needs physical help with dressing or brushing their teeth; it also does not include hand-on reflexive responses to guide or redirect a person from harm or injury (NDIS QSC, 2020).

Environmental restraint: restriction of a person's free access to all parts of their environment, including locking a cupboard or fridge to prevent access, placing restrictions on activities (e.g., cooking or watching television), preventing access to personal possessions (e.g., mobile phone, iPad), restricting access to hazardous items, sharps or chemicals to minimise the risk of self-harm (Australian Government, 2018a; NDIS QSC, 2020).	Environmental restraint is not: locking medication to prevent access. NDIS providers responsible for administering medication must keep medication stored safely and securely, and do not need to report the locking of medication to the commission (NDIS QSC, 2020).
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All regulated restrictive practices used should be the least restrictive practice option possible and used for the shortest possible period to address the behaviour of concern (NDIS QSC, 2020; NSW FCS, 2020). Use of regulated restrictive practice must be outlined in a behaviour support plan and only used within the framework of positive behaviour support (NDIS QSC, 2020).

3. Safe Transportation

A device used for safe transportation, e.g., buckle guard for a seat belt, 'child lock' on a door, adjustable vest to prevent unsafe, unintentional movement in a vehicle, is not a mechanical restraint and does not need to be authorised (DCT, 2019a; DHHS, 2022; NDIS QSC, 2022a; NSW FCS, 2020). However, any device used during transport for the **primary purpose of reducing or preventing a behaviour of concern** is considered a mechanical restraint and subject to authorisation of its use (DHHS, 2020; NDIS QSC, 2022a; NSW FCS, 2020). This includes use of a buckle guard if the client regularly undoes their belt, a harness if the client tries to interfere with the driver or other passengers, and dedicated harnesses that require modification to the vehicle (DCT, 2020a).

Devices used for safe transportation, like seatbelt guards, or to prevent injury, like bed rails, may still be prohibited if they are used for inappropriate purposes, such as for punishment (NSW FCS, 2020).

Further information regarding Safe Transportation can be found via [Restrictive Practice Guide, Safe Transportation \(February 2022\)](#).

4. Prohibited Practices

There are some restrictive practices or actions that will not receive authorisation at any time. Although some states and territories have aligned their prohibited practices, the prohibited practices for each region are described individually below to ensure clarity.

4.1 New South Wales

NSW prohibits the following practices (CRPT, 2019a):

- aversion – a practice that is experienced as noxious or unpleasant and potentially painful to manage behaviour
- overcorrection – a practice where a person is required to respond disproportionately to an event, beyond what is necessary to restore a disrupted situation
- misuse of medication
- seclusion of children or young people
- denial of key needs, including access to bedding, water, climate controls or toilet facilities, personal possessions, access to family, peers and advocates, and other basic needs (NSW FCS, 2022a)
- unauthorised use of a restrictive practice
- act in a way that degrades or demeans a person, may be reasonably perceived as harassment or vilification, or is unethical

The following practices are also prohibited in accordance with the *Children and Young Persons (Care and Protection) Regulation 2012* for participants aged 18 and under (CRPT, 2019a):

- all forms of corporal punishment,
- punishment that takes the form of immobilisation, force-feeding or depriving of food, and
- any punishment intended to humiliate or frighten the person

4.2 Victoria

Provisions have been made under section 27(5B) of the *Disability Act 2006 (Vic)* to prohibit the use of specific restrictive practices. Disability service providers and registered NDIS providers are prohibited from using the following physical restraints on an NDIS participant or person with a disability (s27 *Disability Act 2006 Vic*):

- Prone restraint (subduing a person by forcing them face-down)
- Supine restraint (subduing a person by forcing them face-up)
- Pin downs (subduing a person by holding any part of their body)

- Basket holds (subduing a person by wrapping arms around their upper or lower body)
- Take down techniques (subduing a person by forcing them to free-fall to the floor or forcing them to the floor with support)
- Any physical restraint that has the purpose or effect of restraining or inhibiting a person's respiratory or digestive functioning
- Any physical restraint that has the effect of pushing a person's head forward onto their chest
- Any physical restraint that has the purpose or effect of demanding compliance through pain, hyperextension of joints or applying pressure to chest or joints

Registered NDIS providers are also prohibited under this section of the Act from using restrictive practices on any person with psycho-social disability unless the person also meets the requirements for another disability under section 24 of the *National Disability Insurance Scheme Act 2013 (Cth)*.

4.3 Northern Territory

The following restrictive practices will not be authorised (Northern Territory Government, 2021):

- Supine or prone restraint
- Aversion – a practice that is experienced as noxious or unpleasant and potentially painful to manage behaviour
- Overcorrection – a practice where a person is required to respond disproportionately to an event, beyond what is necessary to restore a disrupted situation
- Misuse of medication
- Denial of key needs, including possessions, access to family, peers, advocates and other basic needs
- Practices related to degradation or vilification
- Practices which limit or deny access to community, culture and language
- Seclusion of a person under 18 years old

4.4 Queensland

The Disability Services Act 2006 (Qld) does not prohibit any types of restrictive practice, but only permits the use of restrictive practice in response to the adult's behaviour that may cause harm to that adult or others. Restrictive practices cannot be used punitively or in response to behaviour that does not cause harm (Queensland Government, n.d.). The lack

of prohibited practices in Queensland is currently under review (Queensland Government, n.d.).

4.5 Tasmania (DCT, 2021a).

- Prone or supine restraint
- Pin downs
- Basket holds and take downs
- Punitive approaches such as aversive practice, denial of key needs, over correction

4.6 South Australia

The Restrictive Practices Schedule highlights the following practices are prohibited (DHS SA, 2022a):

- prone or supine restraint
- physical restraint that is intended to restrict or affect a participant's respiratory or digestive function
- physical restraint that causes deliberate pain or discomfort (including joint hyperflexion, pressure on chest) to secure compliance
- psychosocial restraint (staff behaviour) – such as demeaning tone of voice, threatening negative consequences, manipulation/coercion, leaving people in bed or putting them to bed too early
- psychosocial restraint (staff withholding) – denying access to basic human rights, such as food/drinks/shelter/warmth, clothing, personal belongings, positive social interaction, enjoyable activities, communication devices. Note: if a participant cannot engage in a favourite activity, the provider must ensure the participant understands the activity is rescheduled due to safety and not due to punishment. This should be supported by a risk assessment.
- aversion – such as electric shocks on a person or water sprayed to the face
- exclusion – deliberately ignoring, punishing by denying participation, preventing a person from participating in an activity or decision

4.7 Western Australia

It is recognised that some forms of restrictive practice pose an unacceptable risk of harm to people. These are 'prohibited practices' within the Authorisation of Restrictive Practices in Funded Disability Services Policy (DoC, 2020a) and must never be used. These include the following physical restraints, which can lead to harm or death:

- prone or supine restraint
- pin downs

- basket holds
- takedown techniques
- any physical restraint that has the purpose or effect of restraining or inhibiting a person's respiratory or digestive functioning
- any physical restraint that has the effect of pushing the person's head forward onto their chest
- any physical restraint that has the purpose or effect of compelling a person's compliance through the infliction of pain, hyperextension of joints, or by applying pressure to the chest or joints.

The following punitive approaches are also prohibited:

- aversive practices
- overcorrection
- denial of key needs
- practices related to degradation or vilification
- practices that limit or deny access to culture
- response cost punishment strategies.

4.8 Australian Capital Territory

The *Senior Practitioner Act 2018* (ACT) does not highlight any restrictive practices that are prohibited. The Act outlines the circumstances where restrictive practice can be used and they should not be used punitively or in response to behaviour where there is no risk of harm.

5. Reportable Incidents

A condition of registration is that registered NDIS providers notify the NDIS commission of all reportable incidents that occur (including alleged incidents) in connection with the provision of NDIS supports and delivered services, even if these are recorded within their own incident management system (NDIS QSC, 2022b). These incidents may include (NDIS QSC, 2022b):

- the death or serious injury of a person with disability
- abuse or neglect of a person with disability
- unlawful sexual or physical contact with, or assault of, a person with disability
- sexual misconduct, committed against, or in the presence of, a person with disability, including grooming of the person with disability for sexual activity

- use of restrictive practice in relation to a person with disability where the use is not in accordance with an authorisation of a state or territory in relation to the person, or if it is used according to that authorisation but not in accordance with a behaviour support plan for the person with disability.

Note, if there is no state or territory authorisation process to the use of a restrictive practice then its use is not a reportable incident if used in accordance with a behaviour support plan (NDIS QSC, 2022b). The guide [Reportable incidents](#) provides further information for registered NDIS providers.

Notification should be made through the [NDIS Commission Portal](#) within the required timeframe (see table below, NDIS QSC, 2022b). Timeframes are calculated from when the registered NDIS provider becomes aware an incident occurred or alleged to have occurred.

Reportable incident	Required timeframe
death of a person with disability	24 hours
serious injury of a person with disability	24 hours
abuse or neglect of a person with disability	24 hours
unlawful sexual or physical contact with, or assault of, a person with disability	24 hours
sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity	24 hours
Unauthorised use of regulated restrictive practices, i.e., the use is not in accordance with a required state or territory authorisation and/or not in accordance with a behaviour support plan (N.B. if this incident caused harm to a person with disability, the NDIS Commission must be notified within 24 hours)	Five business days

6. NDIS Behaviour Support Practitioner

NDIS providers who provide behaviour support must use NDIS behaviour support practitioners. An NDIS behaviour support practitioner is someone considered suitable by the NDIS Quality and Safeguards Commissioner and there are provider registration and practitioner suitability requirements.

The following link can be used to search for an NDIS registered behaviour support practitioner by name, postcode or email address:

<https://www.ndiscommission.gov.au/find-ndis-behaviour-support-practitioner>

7. Guide to State/Territory RRP Authorisation

7.1 New South Wales

7.1.1 Entity Responsible

NSW Government, Family and Children Services [Central Restrictive Practices Team](#) (CRPT)

7.1.2 Authorisation

Consent for RRP Authorisation

For seclusion:

- **Under 18:** Seclusion is **prohibited** for any person under the age of 18, e.g., sending a child to their room and preventing them from leaving the room (CRPT, 2019a).
- **Over 18:** The person if they have capacity OR other people, such as a guardian with a restrictive practices function, including a person appointed by the Guardianship Division of the NSW Civil and Administrative Tribunal (CRPT, 2019a).

For chemical, mechanical, physical restraints and environmental restraints:

- **Under 18:** Parent/Guardian OR the person with parental responsibility (e.g., the Minister for Family and Community Services) (CRPT, 2019a).
- **Over 16:** Consent from the person if they have capacity OR a guardian OR a person responsible (if previously agreed), OR as directed by an RPA Panel in limited circumstances (CRPT, 2019a).

General Authorisation Process (CRPT, 2019a; CRPT, 2019b)

1. Behaviour support plan is developed,
2. Informed consent is obtained (see below, 3.1.5 Additional Information),
3. Authorisation is approved by a Restrictive Practices Authorisation (RPA) Panel managed through internal policy and procedures of the registered NDIS provider.

An RPA Panel must include a minimum of three roles:

1. A senior manager familiar with the operational considerations around the use of a restrictive practice in the intended service setting, who chairs the RPA Panel,
2. A specialist with expertise in Behaviour Support, can be provided by FACS or sourced by other means,
3. And a person who is independent of the service provider.

Where behaviour support expertise comes from a person external to the provider who is also not connected to the person with disability, they may serve both behaviour support and independent roles on the panel. In this scenario, the panel is made up of two people:

1. A senior manager familiar with the operational considerations around the use of a restrictive practice in the intended service setting, who chairs the RPA panel,
2. A specialist with expertise in behaviour support, can be provided by FACS or sourced by other means, and who is independent of the service provider.

The Behaviour Support Practitioner, delivering behaviour support, must participate in the RPA meeting to answer questions from the panel.

Interim Authorisations (CRPT, 2019a)

When there is a clear and immediate risk a restrictive practice may need to be used in the absence of a Behaviour Support Plan (BSP). In these circumstances an Interim BSP must be developed within one month of the use of regulated restrictive practice. Interim authorisation can be provided by a senior manager of the NDIS provider who specifies the length of time for which the interim authorisation applies, not exceeding five months.

Management of non-intentional risks (CRPT, 2019a)

Strategies to manage 'non-intentional risk behaviours' do not require authorisation. An appropriate allied health assessment must be used to identify whether behaviours are intentional or non-intentional. If the assessment determines that the behaviour is non-intentional, the response to this behaviour does not require authorisation under the RPA Policy. However, providers should be guided by the NDIS Commission as to whether the circumstance requires a BSP and should comply with reporting and other requirements in line with the NDIS (Restrictive Practices and Behaviour Support) Rules 2018.

These include:

- Behaviours that create physical risk related to mobility, transitioning or accidental movement
- Resistance to support for activities of daily living – behaviours that demonstrate discomfort associated with daily activities (i.e., shaving or brushing teeth)

Unsafe actions that unintentionally place the person at risk (i.e., no knife safety, reaching for a hot kettle, wandering out the front door without awareness of road safety) (CRPT, 2019a)

7.1.3 Lawful Orders

In New South Wales lawful orders, such as an extended supervision order, can direct legally binding restrictions on a person. Lawful orders are considered an authorised restrictive practice (CRPT, 2019a). The practice should still be referred to an RPA panel within 6 months for the purpose of evaluating how the order requirements are integrated into the BSP and its implementation (CRPT, 2019b). The RPA should be provided with a BSP developed after functional behaviour analysis by a registered behaviour support practitioner (CRPT, 2019a). The BSP must include details and limits of the restrictions allowed under the lawful order. Restrictive practices used beyond those permitted by the order must be authorised in the usual manner (CRPT, 2019b). Lawful orders can be placed for up to 5 years, and the Supreme Court can extend the order (CRPT, 2019a).

7.1.4 Additional information provided by the authorising entity

Physical Restraint	Section 158 of the <i>Children and Young Persons (Care and Protection) Act 1998</i> – physical restraint can only be used on a temporary basis and only to the extent necessary to prevent injury to any person, or seize and take from the child or young person: a weapon or object being used in dangerous manner, alcohol, illegal substance or other thing necessary to prevent injury to any person (NSW FCS, 2022c). Section 45 of the <i>Children and Young Persons (Care and Protection) Regulation 2012</i>- Evidence that the child or young person has received support and/or counselling in relation to each instance must be included with an application for authorisation to use physical restraint with a child or young person (NSW FCS, 2022c).
Environmental Restraint	Others impacted by environmental restraint, for example, using a physical barrier like a locked door. An environmental restraint authorised for a person using behaviours of concern is not automatically authorised for use with any other person. In these cases, an RPA Panel must determine whether it is appropriate to authorise the use of the restrictive practice for all members of the household (NSW Family and Community Services (NSW FCS, 2022a).

7.1.5 Further information

[Restrictive Practice Resources Seclusion Guidance](#)

[Restrictive Practice Resources Chemical Restraint Guidance](#)

[Restrictive Practice Resources Mechanical Restraint Guidance](#)

[Restrictive Practice Resources Physical Restraint Guidance](#)

Restrictive Practice Resources Environmental Restraint Guidance

NSW Restrictive Practice Authorisation Policy

NSW Restrictive Practices Authorisation Procedural Guide

7.2 Victoria

7.2.1 Entity Responsible

State Government of Victoria, [Victorian Senior Practitioner](#) (Department of Health and Human Services)

7.2.2 Authorisation

General Authorisation Process (DHHS, 2019a)

- Registered NDIS providers are to appoint an Authorised Program Officer (APO) and are to obtain approval from the Victorian Senior Practitioner for the appointment. Registered NDIS providers must comply with this as a condition of registration before using RRP on NDIS participants.
- If the APO considers the requirements in the Victorian Disability Act 2006 Section 132ZR(1) (State Government of Victoria, 2006) are met, the APO must first ensure that an independent person is made available to the NDIS participant before authorising the use of RRP.
- The independent person must not be: a disability service provider or representative of a disability service provider, or have any interest in a disability service provider which is providing, or has provided, disability services to the person with a disability.
- In addition to the APO authorising the use of the RRP, the Victorian Senior Practitioner must provide approval for the use of RRP on NDIS participants if the practice is in the form of seclusion, physical restraint or mechanical restraint.
- After authorising the use of a RRP, the APO must provide the Victorian Senior Practitioner with required information within two working days, including a copy of the NDIS participant's NDIS BSP, name and details of the independent person who assisted the NDIS participant, any information relating to RRP that is not included in the BSP and any other information required by the Victorian Senior Practitioner.
- After this information is provided to the Victorian Senior Practitioner, the Victorian Senior Practitioner will provide written evidence of authorisation of RRP in the NDIS BSP to the registered provider/behaviour support practitioner.
- The registered provider/behaviour support practitioner must lodge evidence of authorisation to the NDIS Commission.

Use of regulated restrictive practice in an emergency (DHHS, 2019a)

- Use of regulated restrictive practice can be authorised by the person in charge of a registered NDIS provider if there is an imminent risk of serious physical harm to self or others and it is necessary to use a regulated restrictive practice to prevent that risk.
- The least restrictive option must be used
- The APO must be notified as soon as practicable.
- If the regulated restrictive practice will be used again, Part 6A and Part 6B of the Disability Act 2006 must be complied with.

7.2.3 Supervised Treatment Order (DHHS, 2019b)

For an NDIS participant that is subject to a supervised treatment order or interim supervised treatment order, the Victorian Senior Practitioner may give written notice to the NDIS commissioner if:

- VCAT makes an interim supervised order or supervised treatment order
- The Victorian Senior Practitioner approves a material change to a treatment plan
- The supervised treatment order is varied, revoked or expires

The Victorian Senior Practitioner must provide written notice to the NDIS commissioner if an assessment order is made or revoked. An assessment order is made when it is necessary to detain a person with an intellectual disability to prevent a significant and imminent risk of harm to others, allowing a treatment plan to be developed for an application for a supervised treatment order.

An NDIS participant can be subject to a supervised treatment order granted by VCAT and can only be detained in accordance with the compulsory treatment provisions in Div 5 of Part 8 of the *Disability Act 2006* (Vic). For a supervised treatment order the NDIS participant must:

- have an intellectual disability
- be residing in an SDA enrolled dwelling under an SDA residency agreement
- have a treatment plan attaching an NDIS behaviour support plan approved by the Victorian Senior Practitioner, and
- pose a significant risk of harm to others that cannot be reasonably reduced by less restrictive means

A person with an intellectual disability can only be detained under the *Disability Act 2006* (Vic) if a supervised treatment order has been made by VCAT under Part 8 of the *Disability Act 2006* (Vic).

7.2.4 Additional Information provided by the authorising entity

Environmental Restraint	Detain - a form of restrictive practice used on a person for the purpose of reducing the risk of violence or the significant risk of serious harm the person presents to another person and includes physically locking a person in any premises and/or constantly supervising or escorting a person to prevent the person from exercising freedom of movement. This is considered an environmental restraint (DHHS, 2019a).
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7.2.5 Further information

[Authorisation process for the use of regulated restrictive practices](#)

[Victorian Disability Act 2006 Section 132ZR\(1\) V](#)

[Quick reference guide to common questions about restrictive practices – mechanical restraint](#)

7.3 Queensland

7.3.1 Entity Responsible

[Queensland Civil and Administrative Tribunal](#) (QCAT)

7.3.2 Authorisation

General Authorisation Process (DCDSS, 2019a)

Who authorises a restrictive practice depends on:

- Whether the use of the restrictive practice is planned or unplanned
- Type of restrictive practice (containment and seclusion, chemical/mechanical/physical restraint or restricted access to objects)
- Type of disability service the adult is receiving (respite and/or community access only, or accommodation and community support alone, together, or in conjunction with respite and/or community access)

A matrix outlining authorisation of restrictive practice requirements can be found in the document '[Authorising restrictive practices](#)' (DCDSS, 2019a).

Regardless of how many service providers or number of restrictive practices, an adult should only have one BSP developed. Authorisation must be sought by each relevant disability

service provider who intends to implement restrictive practice and for each type of restrictive practice.

Short Term Approval

A short-term approval can be made for a maximum of six months where (DCDSS, 2020a):

- There is an immediate and serious risk of harm to the adult or others; and
- The restrictive practice is the least restrictive way of ensuring the safety of the adult or others

There are two decision makers that can give a short-term approval (DCDSS, 2020a):

- The Public Guardian; or
- A delegate of the Chief Executive of the Department of Communities, Disability Services and Seniors. These delegates are the Principal Clinician in each region. For containment and seclusion, a short-term approval can only be given by the Public Guardian.
- For all other types of restrictive practice, a short-term approval must be sought from a Principal Clinician

After short term approval is provided, the service provider should seek full approval and commence development of the positive BSP (DCDSS, 2020a).

7.3.3 Authorisation for Children

As of December 2020, there is no state based authorisation available for the use of regulated restrictive practices for participants under 18 years old (NDIS QSC, 2021).

Children Under Protection

The Department of Child Safety, Youth and Women (Child Safety) promotes the use of positive behaviour support to all children and young people in care (Department of Child Safety, Youth Justice and Multicultural Affairs, (DCSYJMA), 2020a), in accordance with the legislated standards of care outlined in, the Child Protection Act 1999 (the Act), sections 74 and 122 and the Charter of Rights for a child in care which is set out in Schedule 1 of the Act (Queensland Government, 2020).

The Child Safety Policy: Managing high risk behaviour (DCSYJMA, 2020a), refers to:

- children and young people subject to a care agreement, an assessment order, or an order granting custody or guardianship to the chief executive under the Act, including a temporary custody or transition order, and who are placed in a care arrangement under section 82(1) of the Act, and

- approved foster carers, kinship carers and staff employed by Child Safety and non-government organisations to provide direct care to a child or young person placed under the authority of section 82(1) of the Act

The policy acknowledges that restrictive practices can present risk and contribute to trauma to the child and those using the restrictive practices (Queensland Government, 2021). The Child Safety Policy: Managing high risk behaviour should be read in conjunction with the Positive Behaviour Support (604) policy (DCSYJMA, 2020b).

Principles for emergency use of restrictive practices (DCSYJMA, 2020a):

- the child or young person is behaving in a way that poses immediate risk of harm to themselves or others
- the practice is reasonable in all the circumstances of the behaviour
- there is no less restrictive measure available to respond to the behaviour
- paramount consideration must be given to the best interests of the child

Where restrictive practice has been used to manage high risk behaviour, including physical restraint, details of the incident must be reported by the carer or direct care staff member to Child Safety within 24 hours of the incident (DCSYJMA, 2020a).

7.3.4 Lawful Orders (information received by email from Qld behaviour support)

Restrictive practices should be proportionate to the risk and least restrictive option available. The restrictive practice needs to be outlined in a BSP, lodged with the NDIS commission, authorised in accordance with state requirements and lodged with the NDIS commission, and implementing providers need to complete monthly reporting to the NDIS Commission on the use of restrictive practices

Table note: Where the adult in is receipt of a funded accommodation support package and has additional respite/community access services, the general rule applies (DCDSS, 2019a).

7.3.5 Additional Information provided by the authorising entity

Environmental Restraint (referred to as 'restricted access to objects')	<i>Consent for Authorisation</i> General: Guardian for restrictive practice (general) appointed by QCAT or if no appointment, an informal decision maker (DCDSS, 2019b).
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	When only receiving respite or community access: Guardian for restrictive practice (respite) appointed by QCAT or if no appointment, an informal decision maker (DCDSS, 2019b). The locking of gates, doors or windows where the only reason is to prevent physical harm being caused to the adult with a skills deficit, is not considered a restrictive practice as defined under the Act (DCDSS, 2019d). The relevant service provider must confirm that the person for whom the strategy of locking gates, doors and windows is being considered: • is an adult (18 years or older), • has an intellectual or cognitive disability as defined under Section 144 the Act. The relevant service provider must establish that the practice is not containment, seclusion, or restricting access as defined under the Act (DCDSS, 2019c; DCDSS, 2019d).
Mechanical Restraint	Consent for Authorisation General: Authorisation from the Guardian for restrictive practice (general) appointed by QCAT (DCDSS, 2019e). When only receiving respite and/or community access: Guardian for restrictive practice (respite) appointed by QCAT or if no guardian appointed, an informal decision maker (DCDSS, 2019e).
Chemical Restraint	Consent for Authorisation General: Guardian for restrictive practice (general) appointed by QCAT When only receiving respite and/or community access: <i>For PRN medication-</i> Guardian for restrictive practice (respite) appointed by QCAT <i>If no PRN medication-</i> <i>Fixed does for adult in respite-</i>

	Informal decision maker or guardian for restrictive practices (respite) appointed by QCAT (QCAT, 2021; DCDSS, 2020b) <i>Fixed doses for adults when on community access-</i> Guardian for restrictive practice (respite) appointed by QCAT (QCAT, 2021) *In all cases where chemical restraint is used or proposed, the adult's treating doctor must be involved at all stages of the decision-making process (DCDSS, 2020b). Note: The use of medication such as a sedative, prescribed by a medical practitioner to facilitate or enable the adult to receive a single instance of health care is not considered chemical restraint under the Guardianship and Administration Act 2000. For example, providing a sedative to an adult before attending a dentist appointment (DCDSS, 2020b).
Physical Restraint	Consent for Authorisation General: Guardian for restrictive practice (general) appointed by QCAT (DCDSS, 2020c). When only receiving respite and/or community access: Guardian for restrictive practice (respite) appointed by QCAT or if no guardian appointed, an informal decision maker (QCAT, 2021, DCDSS, 2020c). Practices used to assist the adult with daily living or therapeutic activities, or to keep the adult safe where the adult has a skills deficit and as a consequence is unable to perform a task safely are not intended to be restrictive practices (DCDSS, 2020c).
Seclusion Restraint	Consent for Authorisation General: Authorisation from QCAT (QCAT, 2021) When only receiving respite and/or community access: Guardian for restrictive practice (respite) appointed by QCAT (QCAT, 2021). Providers must work with Department of Communities, Disability Services and Seniors (DCDSS) in the assessment

	for, and development of, all positive BSP which include containment and seclusion (DCDSS, 2019a) NOTE: For all participants over the age of 18 that have containment and seclusion as a restrictive practice must have their plan developed jointly with the DCDSS (DCDSS, 2019a).
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7.3.6 Further information

[Authorising Restrictive Practices](#)

[Restricting Access](#)

[Mechanical Restraint](#)

[Chemical restraint](#)

[Physical restraint](#)

[Containment and seclusion](#)

[Queensland Civil and Administrative Tribunal \(QCAT\): Guardian for restrictive practices](#)

[Child Safety Policy, Positive Behaviour Support \(Policy No 604-5\)](#)

[Locking of gates, doors, and windows](#)

[Child Safety Policy, Managing High Risk Behaviour \(Policy No 646-2\)](#)

7.4 Tasmania

7.4.1 Entity Responsible

Department of Communities, [Office of The Senior Practitioner](#) (DCT, 2020b)

7.4.2 Authorisation

Restrictive Interventions

The Tasmanian Disability Services Act 2011 (section 34) (Tasmanian Government, 2021) describes two categories of restrictive intervention:

- *Environmental restriction*, in relation to a person with disability, means a restrictive intervention in relation to the person that consists of the modification of an object, or the environment of the person, so as to enable the behavioural control of the person, but does not include personal restriction (DCT, 2020c).
- *Personal restriction*, in relation to a person with disability, means a restrictive intervention in relation to the person that consists wholly or partially of (DCT, 2020d):
 - (a) Physical contact with the person to enable the behavioural control of the person or
 - (b) Taking an action that restricts the liberty of movement of the person

- Seclusion is a type of personal restriction. Therefore, use of seclusion must be reported to the Tasmanian Senior Practitioner to obtain authorisation under provisions of the Disability Services Act (Use of a Personal Restriction) (DCT, 2019b).

General Approval Process (DCT, 2021a)

- Restrictive interventions must be part of a positive BSP that promotes positive outcomes for the adult and supports the reduction or elimination of restrictive practices
- After recommendation by the Senior Practitioner, an environmental restriction can be approved by the Secretary of the Department of Communities Tasmania for up to 90 days (section 38), or by the Guardianship & Administration Board for up to 2 years after a hearing (section 42) (DCT, 2021b)
- After recommendation by the Senior Practitioner, a personal restriction can be approved by the Guardianship & Administration Board for up to 90 days without a hearing or for up to 2 years after a hearing (section 42) (DCT, 2021b)

7.4.3 Lawful Orders

Restrictive practices authorised under other enactments relating to mental health services or guardianship do not require approval through the Disability Services Act 2011 (DCT, 2019a) Examples of this include (but are not limited to) (DCT, 2019a):

- (a) Restriction and Supervision Orders under the Criminal Justice (Mental Impairment) Act 1999. These orders might require meeting specific conditions such as confinement in a secure mental health unit, or taking of a particular medication.
- (b) Involuntary admission to an approved facility for treatment (e.g. Treatment Orders Mental Health Act 2013.)
- (c) Treatment approved by 'person responsible', appointed guardian or the Guardianship and Administration Board (Guardianship and Administration Act 1995). For example – medication to control behaviour (Guardianship and Administration Regulations 2017; Section 12)

7.4.4 Additional Information provided by the authorising entity

Environmental Restraint

Surveillance and monitoring can include the process of capturing audio, visual or positional information about a person using electronic methods:

- Audio monitors record and monitor speech, e.g. baby monitors, intercoms;

	• Visual monitors record and monitor visual images, e.g. closed circuit cameras, still image cameras, portable video devices; • Positional monitors record the whereabouts of a person with global positioning system (GPS) devices which are the most commonly available method of monitoring a person's location; • Surveillance and monitoring can also include 'line of sight' supervision in 'real time' by support workers to prevent a person with disability from pursuing a certain course of action (DCT, 2021b).
Mechanical Restraint	A restraint used during transport for convenience of staff is considered a form of abuse (DCT, 2019b).
Chemical Restraint	Under the Disability Services Act, the use of chemical restraint does not need to be authorised. However under regulation 12(a) of the Guardianship and Administration Regulations 2017, there is a legal requirement for the 'person responsible' to consent to the 'administration of a restricted substance primarily to control the conduct of a person to whom it is given' (Tasmanian Civil and Administrative Tribunal, 2021).
Physical Restraint	The use of a bed rail to restrict a person's voluntary movement is a form of physical restraint and the use of a bed rail for this purpose would need approval from the Guardianship and Administration Board (GAB) via an application to the Senior Practitioner (DCT, 2019c). However, the use of a bed rail may not be deemed a personal restriction if: • The person has decision making capacity and has requested bed rails • The person has involuntary movements during the night (e.g. seizures or 'restless' sleep) • The person does not have the skills to get out of bed without support (DCT, 2019c) If a bed rail is being considered it is essential to consult with an OT and the Senior Practitioner (DCT, 2019c). If a bed rail is approved for use then staff must increase their monitoring of the person at risk (DCT, 2019c).
Seclusion Restraint	Seclusion can only be used if it is to prevent harm, used in the least restrictive way possible, and is a last resort and authorised (DCT, 2019b).

	A parent's request for the use of sole confinement does not stop the action from being seclusion. Family members may advise a service provider that they want the person with the disability to be secluded however the service provider will still need to seek authorisation from the Tasmanian Senior Practitioner and report to the Commission (DCT, 2019b). If 'sole confinement', a 'time out', 'time away' or similar practices are used that don't meet the conditions above they will most likely be considered a form of abuse and not as RRP (DCT, 2019b).
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7.4.5 Further information

[Disability Services Act 2011](#)

[Restrictive Interventions in Service for People with Disability Procedure](#)

[Surveillance and monitoring of people with a Disability](#)

[Environmental restrictions](#)

[Personal restrictions](#)

[Locking of Fridges and Pantries](#)

[Use of Bed Rails](#)

[Seclusion](#)

[Restrictive Interventions not Requiring Authorisations](#)

7.5 South Australia

7.5.1 Entity Responsible

[South Australian Civil and Administrative Tribunal](#) (SACAT)

7.5.2 Authorisation

'Levels' of Restrictive Practice

South Australia have outlined two levels of restrictive practice that have differing authorisation processes. The types of restrictive practice in each level are detailed below ([Disability Inclusion \(Restrictive Practices – NDIS\) Regulations 2021](#)):

Level 1:

- Environmental restraints (other than those deemed level 2)
- Mechanical restraints (other than those deemed level 2)
- Chemical restraints (other than those deemed level 2)

Level 2:

- Seclusion (not including detention)
- Environmental restraint consisting of:
 - o Electronic monitoring devices worn by a person
 - o Locking external gates or doors of a residential premises (other than detention)
 - o Continuous accompanying a person
 - o Limitation of access to, or use of, a mobility device (including not charging batteries, application of brakes or otherwise rendering the device inoperative)
 - o Limiting access to communication devices
- Mechanical restraint that requires the use of force
- Physical restraint
- Chemical restraint consisting of:
 - o Administration of a drug by invasive procedure
 - o Use of 2 or more psychotropic drugs
 - o Use of more than 5 different drugs
 - o Hormonal manipulation
- Use of more the five level 1 restrictive practices (whether by the same registered NDIS provider or otherwise)
- Concealment of restrictive practices (Department of Human Services South Australia (DHS SA), 2022b)

Authorisation Officers

- A regulated restrictive practice cannot be authorised by a legal guardian or parent.
- NDIS service providers who implement a regulated restrictive practice for a child or adult must obtain authorisation under the Restrictive Practices Authorisation scheme (DHS SA, 2022c)
- The Restrictive Practices Authorisation Scheme has two levels of authorisation: Authorised Program Officers and Senior Authorising Officers
- An Authorised Program Officer is an implementing provider staff member who has been authorised by the SAO to undertake authorisation of Level 1 restrictive practices and endorse the use of Level 2 restrictive practices for the Senior Authorising Officer's authorisation (DHS SA, 2022d)
- A Senior Authorising Officer is an employee in the South Australian Department of Human Services. A Senior Authorising Officer can authorise level 1 or level 2 restrictive practices (DHS SA, 2022d).

General Authorisation Process

- A service provider's Authorised Program Officer will receive a request for restrictive practice through the online Restrictive Practices System.
- The Authorised Program Officer must ensure the application meets criteria detailed in section 23N of the *Disability Inclusion (Restrictive Practices – NDIS) Amendment Act 2021*:
 - o The NDIS participant is displaying a behaviour that risks harm
 - o The use of Level 1 restrictive practices is necessary to minimise the harm or prevent further harm
 - o The NDIS participant has a behaviour support plan written by a behaviour support practitioner who is employed by an NDIS registered provider
 - o The behaviour support plan was written in consultation with the NDIS participant, and
 - o The use of level 1 restrictive practices is consistent with the NDIS participant's behaviour support plan
- The Authorised Program Officer must review each restrictive practice using these criteria. If a request does not fulfil all criteria, it cannot be authorised.
- Level 1 restrictive practices should only be authorised by the APO where behaviour assessment, support and interventions have been demonstrated, and the restrictive practice is the least restrictive option and is included in a behaviour support plan (DHS SA, 2022d)
- The Authorised Program Officer must refer all level 2 restrictive practice applications to the Senior Authorised Officer (DHS SA, 2022d)
- The Authorised Program Officer must refer applications to the Senior Authorised Officer if (DHS SA, 2022d):
 - o adults under the guardianship of the Public Advocate where the Public Advocate (or delegate) does not support the restrictive practice
 - o children and young people under the custody or guardianship of the Chief Executive, Department for Child Protection, where the legal guardian does not support the restrictive practice
 - o children and young people under the custody or guardianship of the Chief Executive, Department for Child Protection, where the young person is competent to make decisions about restrictive practices and does not agree to the practice
 - o where the legal guardians of the NDIS participant are in dispute about the restrictive practice

- o where the Authorised Program Officer has been directly involved in the behaviour support planning and/or service delivery for the NDIS participant
 - o where the Authorised Program Officer has a personal relationship with the NDIS participant and/or other association that may give rise to an actual or perceived conflict of interest
- If an APO has a conflict of interest, they should refer the matter to another APO in their organisation or the SAO. APO's cannot endorse or authorise restrictive practices where they (DHS SA, 2022d):
 - o Contributed to the development of the BSP
 - o Are involved in day-to-day support or case work for the participant
 - o Have consulted on the case or involved in decision making
 - o Have a personal relationship with the participant
- Section 23N (2) of the *Disability Inclusion (Restrictive Practices – NDIS) Amendment Act 2021* requires the Authorised Program Officer to provide written notice of their authorisation decisions, including whether the authorisation is conditional, the restrictive practices that are authorised, and the date that authorisation ceases. This statement should be provided to the participant and their legal guardian (DHS SA, 2022d).

Authority to Enter, Search and Retain Items (DHS SA, 2022b)

- Sections 23N (5) and 23O (6) of the Disability Inclusion Act 2018 permit registered NDIS providers to:
 - o Enter and remain in premises where a person with disability may be found
 - o Search their clothing and possessions for items than may be used to harm or cause property damage
 - o Take possession and retain these items as necessary for safety
- This provision cannot be used for routine searches to identify behaviours of concern, remove an item a person cannot have but will not cause harm (e.g. junk food), or search for suspected contraband.
- To use this provision, NDIS providers must have reasonable grounds that a person has an object that may cause harm and the search is required for safety.
- The search must be completed quickly and without causing humiliation or offence
- The search cannot include contact or exposure with intimate parts of the body
- The NDIS provider should: ask the person if there is a preferred staff member to carry out the search, ask the person to empty their pockets, use the least amount of force necessary, arrange for another staff member to be present.

Detention SACAT orders

- Detention is defined by Section 23C of the Disability Inclusion Act 2018 as: any direct or indirect curtailment of a person's ability to leave a particular premises or part of a premises, a requirement that a person be and remain at a premises, and the refusal or limitation of access to means that enable leaving the premises (DHS SA, 2022b).
- Regulation 7 prescribes two limited exceptions to this definition: locking of external gates and doors where NDIS supports and services are provided on a 24-hour basis to a person with disability who does not have supports to safely leave, and the temporary confinement (less than 2 hours) of a person with disability in an emergency that is reasonably necessary to prevent harm or is for de-escalation of risk (DHS SA, 2022b)
- Registered NDIS providers cannot apply for detention; detention applications to SACAT must be made by a guardian or substitute decision (DHS SA, 2022b).
- Detention must be authorised by another legal authority, such as SACAT under section 32 of the *Guardianship and Administration Act 1993* (called special power orders) (DCSI, 2015; SACAT, 2020). Further details about special power orders are in Table 3.6.4 below

7.5.3 Lawful Orders

- SACAT is responsible for Detention and Treatment Orders and Community Treatment Orders (Legal Services Commission, 2022)
- The *Safeguarding People with Disability Restrictive Practices Policy* currently does not cover community treatment orders made under the Mental Health Act 2009 (DCSI, 2015).

7.5.4 Additional Information provided by the authorising entity

Environmental Restraint	Special powers order under s32 (1) (a) – directed residence/enforceable environmental restraint – SACAT can make an order to direct that a person reside in a specified place, or in such place as the guardian or substitute decision maker from time to time thinks fit. A directed residence order will authorise the subject person's residence in the specified place and will enable the guardian or substitute decision-maker to ensure the person can be brought back if they leave
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	that place (with police assistance if necessary) (SACAT, 2020).
Mechanical Restraint	Special powers order under s32 (1) (c) - physical restraint/use of force in care or treatment - SACAT can make an order to authorise persons involved in the care of a person to use such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment or day to day care and wellbeing of the person. This order will authorise care providers to use physical force/restraint as necessary to prevent or restrict a person's movements when administering medical treatment or health care including in the use of any type of chemical, environmental or mechanical restraint (SACAT, 2020).
Chemical Restraint	Special powers order under s 32(1) (c) - physical restraint/use of force in care or treatment - SACAT can make an order to authorise persons involved in the care of a person to use such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment or day to day care and wellbeing of the person. This order will authorise care providers to use physical force/restraint as necessary to prevent or restrict a person's movements when administering medical treatment or health care including in the use of any type of chemical, environmental or mechanical restraint (SACAT, 2020).
Physical Restraint	Special powers order under s 32(1) (c) - physical restraint/use of force in care or treatment - SACAT can make an order to authorise persons involved in the care of a person to use such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment or day to day care and wellbeing of the person. This order will authorise care providers to use physical force/restraint as necessary to prevent or restrict a person's movements when administering medical treatment or health care including in the use of any type of chemical, environmental or mechanical restraint (SACAT, 2020).
Seclusion Restraint	Special powers order under s32 (1) (b) – detention or seclusion of the person in the place in which he or she is directed to reside under s 32 (1) (a) – SACAT can make an order to authorise detention, namely, that direct or indirect

	restrictions are placed on the person's liberty or freedom of movement so that they may not freely come and go from a place, or any part of the place. The order will authorise restraints on the person leaving and will enable the person to be brought back if they leave or are removed from that place (with police assistance if necessary) (SACAT, 2020).
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7.5.5 Further Information

[Restrictive Practices Guidelines](#)

[Restrictive Practices Manual for Implementing Providers](#)

[Restrictive Practices Schedule](#)

[Restrictive Practices and Special Powers](#)

7.6 Western Australia

7.6.1 Entity Responsible

The [Department of Communities](#) (DoC, 2020b)

7.6.2 Authorisation

General Authorisation Process (DoC, 2020c)

- Authorisation must be obtained by an Implementing Provider for each RRP that is proposed to be implemented for a person with disability.
- From 1 May 2021, authorisation requires restrictive practices to be included in a BSP and introduces a mandatory Quality Assurance Panel which allows for independent review of the BSP and the proposed restrictive practices.
- The Authorisation Panel must include at least two members with a decision-making role:
 1. A senior manager (or their delegate) with the Implementing Provider with operational knowledge and relevant experience in behaviour support,
 2. An NDIS Behaviour Support Practitioner who is not the BSP author and not employed by the Implementing Provider.

Additional members may be included in the panel.

NOTE: The Panel's recommendation to use a regulated restrictive practice must be supported by **all** panel members, specify the length of time for which the authorisation applies, which must not exceed 12 months, detail conditions they decide to impose as part of the approval of the restrictive practice, and be recorded in the Quality Assurance Outcome Summary Report (Appendix 3 of the guidelines)

- BSPs developed by Behaviour Support Practitioners that include a restrictive practice, should involve consultation with the person with disability and if appropriate, their guardian, family and carers.
- The NDIS Behaviour Support Practitioner will consult with the person with disability to identify their needs and preferences in a calm and supportive environment
- The BSP must include strategies that are evidence-based and person centred and take account of the functions of the behaviour being considered, as well as any unmet needs that may be contributing to the behaviour

7.6.3 Lawful Orders (DoC, 2020a)

- where a practice that would otherwise be a regulated restrictive practice is in place due to a court order, authorisation is not required under the 'Authorisation of Restrictive Practices in Funded Disability Services' Policy
- Implementing providers may request advice from the NDIS Commission or appropriate department regarding whether the circumstances require a behaviour support plan and compliance with NDIS (Restrictive Practices and Behaviour Support) Rules 2018

7.6.4 Additional Information provided by the authorising entity

Environmental Restraint	Surveillance is the tracking of a person's behaviour or movement by audio, visual or location data (DoC, 2020a). It also includes accompanying a person or keeping them in line of sight at all times (DoC, 2020a; DoC, 2020d).
Chemical Restraint	The BSP must record the prescribing doctor's contact details, medication brand and chemical name, dosage and frequency, conditions and limitations of use, route, side effects, circumstances when the restraint is to be used, anticipated positive and negative effects of the medication, and why the medication is considered the least restrictive method of ensuring safety of the person and others. (DoC, 2020e)

7.6.5 Further Information

[Procedural Guidelines for Authorisation of Restrictive Practices in Funded Disability Services Stage 2](#)

[Authorisation of Restrictive Practices in Funded Disability Services Policy](#)

[Authorisation of restrictive practices](#)

[Chemical restraint](#)

Surveillance

7.7 Australian Capital Territory

7.7.1 Entity Responsible

ACT Government, Community Services, [Office of the Senior Practitioner](#)

7.7.2 Authorisation

General Authorisation Process

A restrictive practice by a service provider is only permissible if used in a way that is consistent with a positive BSP for the person. The positive BSP must be approved by a registered positive behaviour support panel and registered by the Senior Practitioner (Community Services, 2018). The process is as follows:

- The provider must submit a positive BSP to a positive behaviour support panel for approval. Submission must occur one month prior to the Central Panel meeting, and the application must include the completed positive BSP approval panel template, copy of positive BSP and supporting documentation for the restrictive practice (e.g. reports from medical team, risk assessment) (Office of the Senior Practitioner (OSP), 2020b)
- The Central Panel will give the applicant/service provider written reasons for its decision to approve or not approve a positive BSP within one week of meeting (OSP, 2020b)
- If approved, the Central Panel will forward the positive BSP to the Senior Practitioner for registration within 28 days (OSP, 2020b). The Senior Practitioner may request further information from the Central Panel or applicant. When satisfied, the Senior Practitioner will send the provider, public advocate (if the person is under 18) and plan author: a copy of the approved plan and plan registration number (OSP, 2020b).
- The use of any restrictive practice within an approved plan is only authorised once registration has been confirmed by the Senior Practitioner (OSP, 2020b)
- Providers are required to monitor and record use of restrictive practices and forward reports to the Senior Practitioner (Community Services, 2018). For routine and 'as needed' restrictive practices identified within a positive BSP the report should be forwarded by the 5th day after the end of the month.
- The approved positive BSP must be reviewed monthly by the provider to determine whether restrictive practice is still required (Community Services, 2018).

Use of regulate restrictive practice in an emergency:

- Under Section 10 of the *Senior Practitioner Act 2018* (ACT), a restrictive practice must not be used outside of a registered PBS Plan unless (Community Services, 2021; OSP, 2020a):
 - o Provider or relevant person for the provider believes on reasonable grounds that it is necessary to use the restrictive practice to avoid imminent harm to the person or others
 - o Restrictive practice is the least restrictive of the person as is possible in the circumstances having regard to the kinds of restrictive practice that may be used, how it is applied, and how long it is applied for
 - o If practicable – the use of the restrictive practice is authorised by the person in charge of the provider.
- Emergency restrictive practices not identified within a positive BSP must be reported to the Senior Practitioner within 24 hours of the event (Community Services, 2018)

7.7.3 Lawful Orders

Under the *Senior Practitioner Act 2018* (ACT), a person acting under the *Corrections Management Act 2007*, *Children and Young People Act 2008* (Chapters 4 to 9), *Mental Health Act 2015* and *Mental Health (Secure Facilities) Act 2016* are exempt from provider obligations with respect to restrictive practices.

7.7.4 Further Information

[ACT Senior Practitioner for the elimination and reduction of restrictive practices](#)

[Senior Practitioner Act 2018](#)

[Positive Behaviour Support Plans Factsheet](#)

[Positive Behaviour Support Plan Guideline](#)

[Positive Behaviour Support Panel Guideline](#)

7.8 Northern Territory

7.8.1 Entity Responsible

Northern Territory Government, [Northern Territory Senior Practitioner](#)

7.4.2 Authorisation

General Authorisation Process (NT Government, 2021)

An NDIS provider may apply to the Senior Practitioner for an authorisation or interim authorisation. An application for an authorisation or interim authorisation must be made in the approved form and include:

- particulars of the restrictive practice proposed to be applied to the participant

- a copy of the BSP or interim BSP that specifies the proposed restrictive practice
- information that shows the provider has engaged in consultation about the proposed use of a restrictive practice with: (a) the participant; and (a) the participant's family, carers, guardian or other relevant person
- particulars of the NDIS provider who will apply the restrictive practice to the participant
- details of restrictive practice applied to the participant over the 12-month period before the date of the application (authorised and unauthorised)
- any other information the NDIS provider considers relevant to the application
- any other information as prescribed by regulation

The Senior Practitioner must consider the application and decide whether to:

- grant the authorisation or interim authorisation; or
- refuse to grant the authorisation or interim authorisation – NDIS provider will be notified of the reasons for the decision; or
- request further information or propose an alternative restrictive practice for the authorisation or interim authorisation. Responses to a request for further information is required within 28 days or the application will lapse.

Authorisations only apply to the jurisdiction they are made in. If a participant relocates to the NT a new authorisation application will need to be made to the NT Restrictive Practices Authorisation Unit (NT Government, 2021).

Period of authorisation (NT Government, 2021)

- An authorisation is effective for 12 months from the date the authorisation is made, unless otherwise specified by the Senior Practitioner in the authorisation.
- An interim authorisation is effective for 6 months from the date the authorisation is made, unless otherwise specified by the Senior Practitioner in the authorisation.

Change of circumstances (NT Government, 2021)

- If there is a change in circumstances meaning the NT Restrictive Practices Authorisation Unit is no longer required, the service provider must notify the Restrictive Practice Authorisation Unit via email as soon as possible after the change
- Change of circumstance includes: elimination of restrictive practice, interstate move, exiting the NDIS or notification of deceased participant.

7.8.3 Lawful Orders (information received by email from NT behaviour support)

Reporting obligations for the NDIS Commission are via the reportable incident function prior to a BSP lodgement as 'unauthorised restrictive practice'. Once a practitioner has been engaged and develops a BSP, lodges it on the BS portal the forensic order becomes the authorisation and the plan includes reference to the order and how the provider can best support or facilitate the conditions of the order.

7.8.4 Further information

[National Disability Insurance Scheme \(Authorisation\) Act 2019](#)

[Restrictive Practices Authorisation Framework. Guidelines for NDIS Service Providers](#)

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Consultation

Entity	Summary of Consultation
C. s47F - personal (TAB research)	Document creation, Research on WA, SA and ACT
R. s47F - personal privacy (TAB Advisor)	Preliminary research on NSW, QLD, NT, TAS, and VIC
J. s47F - personal privacy (TAB research)	Review
SJP131 (TAB research)	Review
SJP131	Updated links, removed redundant information

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Revision	1	Date	00/0000	Sections	All	Summary of Changes	Original
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Note: Document uncontrolled in hardcopy



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The contents of this document are **OFFICIAL**

Capacity Building (Restrictive Practice) TA Guidance Document

Guidance Document Overview

Advice Area Details

Advice Theme: Capacity Building Supports

Advice Sub-Theme: Relationships or Behaviour Supports

Advice Topic: Restrictive Practice

IMPORTANT: This document is intended to be utilised as a guide to support the TAPIB with providing consistent and high quality advices. Whilst some sections provide statements to support consistency to the Agency, Advisors are to consider advice requests individually and apply critical thinking to participants' unique circumstances.

This document should be read in conjunction with the Restrictive Practice Supplementary Guide that contains detailed information on restrictive practice processes, reportable incidents, authorisation requirements, Practitioner requirements and state-based legislation/policy.



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Technical Advice Case Details Section

Documents Referenced:

Structure to copy into the template

No extra content needs to be added to this section.

Guidance

- List one or two documents reviewed which will directly inform funding of behaviour support.
- Use this format: Title/Description of document, Author, Profession, Date. If you refer to the document again, indicate Author, Date only

Are any other legislative references required?:

Structure to copy into the template

NDIS (Restrictive Practice and Behaviour Support) Rules 2018

Guidance

- Section 34.1 of the NDIS Act 2013; and NDIS (Supports for Participants) Rules 2013 is already referenced at the end of the advice, so there is no need to add them here.

Advisors' Additional Comments

Structure to copy into the template

- [Participant's Name] is [Age] years old with a primary disability of [list primary disability] and secondary disability of [list secondary disabilities].
- Other disabilities and health conditions [(author surname, date)]
- [Participant's Name] resides in [State/Territory].
- Behaviours of concern: [Verbal aggression, physical aggression towards others, property damage/destruction, harm to self – physical, harm to self – other, seclusion/containment, inappropriate sexualised behaviour, inappropriate social behaviour, food bingeing, eating items non-food related, other [list]].



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- Restrictive practices: [environmental restraint, chemical restraint, physical restraint, mechanical restraint, seclusion]
- Implemented by [Detail who is implementing RP e.g. NDIS funded supports, family only, school or detail if it is unknown]

Guidance

- Only list further information if it will impact the behaviour support funding decision i.e., informal supports, summary of situation or other conditions they have not met access for. E.g., they have a diagnosis of ADHD and the medication administered is for the purpose of treating ADHD.
- Refer to Restrictive Practice Supplementary Guide for information particular to state and territory based restrictive practices e.g., Queensland seclusion/containment directive for planning; safe transportation; seclusion for children in NSW prohibited; children in Queensland not subject to state-based authorisation; Supervision Treatment Order in Victoria; different states with various prohibited practices, therapeutic support vs restrictive practice; surveillance and monitoring etc.
- Add the info re behaviour support funding below only if there are no documents that are relevant for advice or there is a funding issue such as no behaviour support funding or under/over utilisation. This information can indicate if funding is or has been utilised, which demonstrates engagement with a Behaviour Support Practitioner, and may indicate a Behaviour Support Plan has, or is being developed (and perhaps not provided to the Agency).

Behaviour support funding to date:

CB Improved Relationships funding in current plan dated [plan period] includes the amount of \$[enter amount]

- [Comment on expenditure such as limited or overutilisation of spending noted for]
- [A Behaviour Support Plan was not located during file review] OR
- [Requestor advised a Behaviour Support Plan has not been supplied as part of review documents/has not been developed] OR
- [Reports on file indicate that despite funding included in the plan, a Behaviour Support Plan is not available for review and is unlikely/likely to have been developed].



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Advisor Opinion

Structure to copy into the template

Funding of behaviour support meets S34.1 criterion of the NDIS Act 2013 to fund.

- Refer to the Practice Guide- Positive Behaviour Support and Behaviours of Concern.
- It is recommended that the participants support needs align to those requiring funding commensurate with level 1/2 behaviour support.
- Funding should include:
 - 45/90 hours of Specialist Behavioural Intervention Support in the budget line of "Specialist Behaviour Intervention Support"
 - 20/30 hours in the budget line of "Behaviour Management Plan including Training in Behaviour Management Strategies".

Provision of these supports must be done by a registered positive behaviour support practitioner and in accordance with the NDIS (Restrictive Practice and Behaviour Support) Rules 2018 ("The Rules").

Additional Information

Provide information to the participant regarding behaviour support:

- Should the participant be funded for Coordination of Supports it is recommended that any Request for Service clearly states the purpose of the funding.
- If the participant is not funded for Coordination of Supports, the Delegate/Planner/Local Area Coordinator/Partner in the Community should explain the purpose of funding and reporting requirements to the participant, their child representative/nominee.
- The following information should be given to the Coordinator of Supports in the Request for Service or the participant/child representative/nominee:
- Specialist Behavioural Intervention Supports are funded to develop a Positive Behaviour Support Plan, by a Behaviour Support Practitioner Registered with the NDIS Quality and Safeguards Commission.
- In accordance with the NDIS (Restrictive Practice and Behaviour Support) Rules 2018, the Behaviour Support Practitioner must use the funding to:
 - Develop an interim Behaviour Support Plan within one month of engagement of the Behaviour Support Practitioner and working with the participant.
 - Complete a Functional Behavioural Assessment.



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- Develop a Comprehensive Behaviour Support Plan within six months of starting work with the participant.
- Implement and train, the participant, their support staff and/or family how to use the Behaviour Support Plan to support the participant to address their needs and reduce behaviours of concern. Where restrictive practices are being used, the plan must also explain what support staff and/or families need to do to fade those practices out over time.
- Provide ongoing review of the Behaviour Support Plan, use of restrictive practices and strategies over a 12-month timeframe.
- The Behaviour Support Practitioner is encouraged to provide a copy of the Positive Behaviour Support Plan (interim, comprehensive) and submit a Progress Report to the NDIS to help with decisions about funding supports in future plans.
- Provide the following fact sheets:
 - [Factsheet: Implementing providers: Facilitating the development of behaviour support plans that include regulated restrictive practices \(ndiscommission.gov.au\)](https://www.ndiscommission.gov.au/factsheet/Implementing-providers-Facilitating-the-development-of-behaviour-support-plans-that-include-regulated-restrictive-practices)
 - Factsheets (five in total): [Participant Fact Sheets for Behaviour Support | NDIS Quality and Safeguards Commission \(ndiscommission.gov.au\)](https://www.ndiscommission.gov.au/factsheets/Participant-Fact-Sheets-for-Behaviour-Support)
 - Flowchart: [Registration requirements for the use of regulated restrictive practices \(ndis.commission.gov.au\)](https://www.ndis.com.au/registration-requirements-for-the-use-of-regulated-restrictive-practices)

Please note the provision of the Fact Sheets and Flowchart is at the request of the NDIS Quality and Safeguards Commission and must be provided to the participant/representative/nominee.

Note to Home and Living Panel or Higher Delegate reviewing NDIS funded supports

- The TAPIB Advice pertaining to funding of behaviour support remains valid for 12 months from advice provision related to a mandatory RP criteria. TAPIB advice regarding funding of behaviour support does not need to be obtained again to support NDIS Plan review/approval within 12 months of the provision of this TAPIB advice.
- The criterion for mandatory TAPIB advice has been updated: to determine whether further advice is required once 12 months has elapsed, please refer to the criterion for seeking mandatory TAPIB advice, and assess whether the participant required further advice.



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Guidance

Children 8 and under

For National Early Childhood (NEC) participants or those that are 7 and 8 years old that have aged out of early childhood intervention (ECI) and are planned for in National Delivery/LAC/planners or partners:

- **Children 8 and under** we will typically only fund **Level 1** even when there are RP identified. If recommending Level 2 this will need Executive Level (EL1) endorsement
- Note: the Practice Guide - Positive Behaviour Support has not yet been updated to reflect this change, however TAPIB will deliver advice in alignment with the change to the age of the early childhood cohort.

Social skills development funding

The below social skills info is for funding that is typically used for therapy assistant. Only add below social skills development funding info for participants that:

- Are not an early childhood participant (under 9 years old)
- Are participants (greater than 9 years old) and not funded 24/7

Up to 40 hours for Individual Social Skills Development in the budget line of "Individual Social Skills Development". For Level 1 and 2 behaviour intervention Delegate to consider the purpose of the Individual Social Skills Development supports as inclusion of this support may require adjustment of hours within the core budget to avoid duplication. Determination as to whether the support is included is at the delegate's discretion.

Provide information to the participant regarding behaviour support:

This paragraph is included as an instruction from the NDIS Quality and Safeguards Commission to ensure every participant is provided with information on the intended purpose of behaviour support and the need for it to be undertaken by a registered Behaviour Support Practitioner.

Unauthorised use of Restrictive Practice: Report of Participant Critical Incident Required

This section is included due to the legislative requirements for restrictive practice to be authorised as a safeguard to all participants who are recipients of restrictive practices].

Only add the info below to advice where unauthorised use of RRP is identified – restrict to instances where it is clear that the practice is not authorised such as no behaviour support funding in prior plans, there is no need to add where there is a behaviour support plan on file, prior funding of behaviour support, remove this box of information before publishing the document for use.



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- Where authorisation of the use of restrictive practice has not been obtained, this is likely to represent the unauthorised use of a restrictive practice and constitute a participant critical incident.
- [Describe why unauthorised RRP is suspected here such as there is no Behaviour Support Plan available on the business system, no evidence of authorisation, limited expenditure of CB Relationships budget.]
- The Planner/Local Area Coordinator/Partner in the Community should confirm the current authorisation status of the restrictive practices being implemented and if authorisation for the use of restrictive practice is not in place, progress with a participant critical incident.
- The Participant Critical Incidents team within the Participant Critical Incidents, Complaints and Resolution and Oversight Branch maintains oversight of all participant critical incidents that come to the attention of the Agency.
- For further assistance regarding submitting a critical incident, please refer to the [Participant Critical Incident Framework](#), [Practice Guide Participant Critical Incidents](#) and relevant SOP such as [Internal Notification of a Participant Critical Incident](#).
- Please note that submission of a participant critical incident should not impact upon Section 34.1 reasonable and necessary decision making or delay funding of behaviour support.

Provider Registration Requirements

Add the Provider Registration Requirements info below ONLY where it has been identified that the behaviour support plan was authored by an unregistered behaviour support practitioner or the restrictive practices are being implemented by unregistered provider (usually flagged by requestor or indicated in evidence), it is not required for all advices.

[add brief context to who is not registered and include who indicated this info]

- **Positive Behaviour Support Practitioners:**
 - The NDIS legislative framework regulates NDIS providers by imposing conditions of registration on providers delivering specialist behaviour support services and providers implementing behaviour support plans that contain regulated restrictive practices.
 - The NDIS legislation recognises that States and Territories may authorise or permit use of a restrictive practice in limited circumstances and imposes conditions of registration on NDIS providers to regulate any such use.
 - The NDIS (Provider Registration and Practice Standards) Rules 2018 state that "a person must be registered under section 73E of the NDIS Act 2013 to provide specialist behaviour support services to a participant if the person will, as part of the



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provision of the services (a) undertake a behaviour support assessment (including a functional behavioural assessment) of the participant; or (b) develop a behaviour support plan for the participant".

- In addition, the NDIS (Restrictive Practices and Behaviour Support) Rules 2018 state there is a "requirement to use a NDIS behaviour support practitioner". This means a Behaviour Support Plan (with or without restrictive practices) can only be developed by:
 - o Providers that are registered for behaviour support (registration group 110)
 - o Behaviour Support Practitioners who are considered suitable by the NDIS Quality and Safeguards Commission to undertake functional behaviour assessments and develop BSP's.

Implementing Providers ("Core Supports")

- As noted above implementing providers must be appropriately registered.
- If the Delegate/Planner/Local Area Coordinator/Partner in the Community believes that there may be a risk that the participant/their nominee may be using an unregistered provider for either behaviour intervention supports or for the implementation of regulated restrictive practices (RRP) such as support workers implementing RRP, talk to the participant/nominee/family/guardian to explain the requirement that NDIS funded supports implementing RRP need to be registered with the NDIS Quality and Safeguards Commission. The Fact Sheets should be utilised in these discussions.
- Reference can be made to the [NDIS \(Plan Management\) Rules 2013](#), [SOP Complete the Determine Plan Management task](#) and [SOP Complete the Risk Assessment task](#) to determine the next steps in managing any potential risk regarding the use of unregistered providers including possible [Participant Critical Incident Framework.docx \(ndia.gov.au\)](#).

Additional Considerations

This section is included where there needs to be consideration of Section 34.1 of the NDIS Act 2013, NDIS (Supports for Participants) Rules 2013 and relevant Operational Guidelines. Example, participant is subject to court order conditions that appear on the "supports that are not NDIS supports" list such as monitoring and supervising participant with a view to prevent offending and ensure compliance with court orders. This is listed in the "not an NDIS support" list and is the responsibility of mainstream Justice. Consider the following inclusions where applicable, however ensure they are tailored to the participant's circumstances:



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Mental Health/Alcohol and Substance Use:

- The information provided suggests the participant requires ongoing treatment and management of her/his mental health presentation/ eating disorder/ alcohol use through the mental health system/Eating Disorders Outreach and Consultation Service/ drug and alcohol services.
- Below are not 'NDIS supports' (Sections 34.1 (f) and 10 of the NDIS Act 2013) include:
- Treatment for drug and alcohol dependency, eating disorders, gambling and other addictions.
- Treatment supports related to mental health that are clinical in nature, including acute, ambulatory and continuing care, rehabilitation/recovery; or
- It will be important to ensure that any NDIS behaviour intervention supports work alongside other supports not funded by the NDIS. NDIS supports are not used for the purpose of providing additional supervision during acute mental health /health/rehabilitation presentations to substitute for review and treatment by mental health/ health/ alcohol and substance rehabilitation services.
- Part of the role of the behaviour support practitioner should also include liaison and referral to mainstream services to determine the responsibilities of other parties including linking with the mental health/health system to address the impact of other contributing factors such as the participant's mental health concerns and drug/substance misuses. This should include clarifying and determining when other mainstream service systems should be activated to provide support to the participant (e.g. emergency response protocols).
- The focus of this support should be around establishing skill development and capacity building supports in the context of the participant's disability (e.g., cognitive impairment) and the extent to which this impacts upon BoC.

Justice:

- NDIS supports related to a participant's involvement with the Justice system are outlined in Section 34.1 (f) and Section 10 of the NDIS Act 2013. [The Operational Guidelines – Justice System](#) provides planning considerations for participants who are in custody, exiting a custodial setting such as prison or forensic mental health services, or has a lawful order with conditions in place.
- Supports that are not 'NDIS supports' (Sections 34.1 (f) and 10 of the NDIS Act 2013) include:
- Supports for offence specific interventions, which aim to reduce specific criminal or offending behaviours, reasonably adjusted to the needs of people with a disability.



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- Assessment and reporting in regard to offending behaviour to meet requirements for the justice system. Whilst a BSP can refer to a participant's lawful orders and associated conditions, the focus should be on BoC as a result of disability related support needs.
- Part of the role of the behaviour support practitioner should also include liaison and referral to mainstream services to compliment NDIS supports with other Justice system services addressing offence related supervision or monitoring, implementation of orders, and how the Justice system aim to transition this participant successfully into the community.

Early childhood participants

- Add below early childhood information only for national early childhood (NEC) participants (up to 9 years old). We do not add this info for participants that are 7 or 8 years old that have aged out of the NEC cohort and are being planned for by National Delivery/LAC/planners or partners).
 - When reviewing this advice please consider the Capacity Building Daily Activity budget to ensure an appropriate level of early childhood supports is funded based on the child's functional needs.
 - This should include consideration of any barriers to participation in daily life across natural settings, including mainstream and community settings. Where funding is allocated for an area of need and it is primarily required due to the behaviours of concern, an adjustment to the level of funding for that area of need should be considered. This will prevent overfunding the support for behaviours of concerns as this is already funded in the Capacity Building Relationships support category.
 - The National Early Childhood branch can provide support if you have any additional questions regarding plan development relating to the early childhood approach.



Advisor Recommendations / Next Steps for Requestor

Structure to copy into the template

1. Funding of behaviour support meets S34.1 criterion of the NDIS Act 2013 to fund.
2. It is recommended that the participants support needs align to those requiring funding commensurate with level 1/2 behaviour support.
3. Funding should include:
4. 45/90 hours of Specialist Behavioural Intervention Support in the budget line of "Specialist Behaviour Intervention Support"
5. 20/30 hours in the budget line of "Behaviour Management Plan including Training in Behaviour Management Strategies".
6. Provision of these supports must be done by a registered positive behaviour support practitioner and in accordance with the NDIS (Restrictive Practice and Behaviour Support) Rules 2018 ("The Rules").
7. Implementing providers of restrictive practice must be a registered service provider and in accordance with the NDIS (Restrictive Practice and Behaviour Support) Rules 2018 ("The Rules").

Guidance

Ensure you detail whether Level 1 or Level 2 is reasonable and necessary (incl. hours for L1 & L2).

There may be very limited circumstances where above L2 behaviour support is recommended and, in these cases, EL discussion is expected.

It may also be applicable to include the following as an additional recommendation (#4):

- Up to 40 hours for Individual Social Skills Development in the budget line of "Individual Social Skills Development". For Level 1 and 2 behaviour intervention Delegate to consider the purpose of the Individual Social Skills Development supports as inclusion of this support may require adjustment of hours within the core budget to avoid duplication. Determination as to whether the support is included is at the delegate's discretion.

If you have detailed a potential or actual unauthorised restrictive practice, include the following:

- The Planner/Local Area Coordinator/Partner in the Community should confirm the current authorisation status of the restrictive practices being implemented and if authorisation for the use of restrictive practice is not in place, progress with a participant critical incident.

For Early Childhood participants, include the following recommendation:



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- When reviewing advice, consider the Capacity Building Daily Activity budget to ensure an appropriate level of early childhood supports is funded based on the child's functional needs.

Template Document control

Version Control

Version #	Status	Date	Modified by	Brief Description of Modification
v0.0	Drafted	07/05/2024	BHN197	Working group leader, submitted finalised draft for formatting
v0.1	Drafted	16/05/2024	BHN197	Working group leader, submitted finalised draft for formatting
v0.1	Drafted	11/09/2024	RWT052	Final formatting prior to submission
v0.1	Endorsed	13/09/2024	EW0013	Endorsed v0.1 with no alterations
v0.2	Drafted	20/09/2024	RWT052	Small revisions based on final comments from working group members
v0.2	Endorsed	20/09/2024	EW0013	Endorsed v0.2 with no alterations
v1.0	Cleared	14/10/2024	KM0032	Cleared v1.0 after updates to content that reference Supports for Participants Rules Schedule 1

Note: Document uncontrolled in hard copy

Consultation Statement

Consultant	Nature of Consultation
ARK468, BDN145, EW0013, JFK288, JKO423, JLM854, KIM222, KM0032, KT0017, NHC740, NIB743, NIH827, SPM343, SRL469, SVO008	Part of the working group that developed the v0.0 template.
NIH827	Designated as Domain Lead for this document.



Technical Advice and Practice Improvement Branch
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DRAFT

Reducing Applied Behaviour Analysis over time

The content of this document is OFFICIAL.

Please note:

The research and literature reviews collated by our TAB Research Team are not to be shared external to the Branch. These are for internal TAB use only and are intended to assist our advisors with their reasonable and necessary decision-making.

Delegates have access to a wide variety of comprehensive guidance material. If Delegates require further information on access or planning matters, they are to call the TAPS line for advice.

The Research Team are unable to ensure that the information listed below provides an accurate & up-to-date snapshot of these matters

Research question: Is there substantial evidence that a step-down transition away from Applied Behaviour Analysis (ABA) therapy can provide outcomes and be of benefit?

Date: 3/1/24

Requestor: s47F - personal privacy

Endorsed by: Naomi s47F - personal privacy

Researcher: Stephanie s47F - personal privacy, Aaron s47F - personal privacy

Cleared by: Stephanie s47F - personal privacy

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2. Summary

This paper considers the evidence for a step-down model of reducing frequency or intensity of applied behaviour analysis (ABA). No evidence was found regarding the effectiveness of a step-down model. One international ABA accreditation body, the Behavioral Health Center of Excellence, recommends a gradual reduction in hours when concluding ABA therapy.

Five papers were attached with the research request. None of the papers directly relate to the efficacy of a step-down model of reducing ABA supports.

Previous TAPIB research has found a lack of consensus regarding appropriate intensity and duration of ABA therapy. Recent Australian guidelines on the delivery of supports for children with autism note that supports should be individualised and there is no set number of hours of therapy which are appropriate for every child.

3. Previous TAPIB research papers

Previous TAPIB research papers related to ABA include:

- [RES 246 ABA and positive behaviour support.docx](#)
- [RES 292 Applied behaviour analysis for adults with ASD.docx](#)

RES 246 found no evidence for appropriate frequency, intensity or timeframe of ABA required to affect a reduction in behaviours of concern, nor any information on reducing intensity of support over time.

RES 292 found lack of consensus regarding appropriate frequency, intensity or timeframe of ABA. The studies review in this paper emphasised that an individualised approach to determining frequency, intensity and timeframe of supports is required.

4. Review of Provided Literature

Five papers were attached with the research request (refer to [6. Literature Review](#) table for further details). None of the attached papers were directly relevant to the research question. None of the papers reviewed directly addressed the benefits of an extended timeframe of supports or the benefits of slowly reducing ABA support over time. No quality assessment was completed due to lack of relevance to the research question.

5. Other sources

The Behavioral Health Center of Excellence (BHCE) is a private organisation that offers accreditation of applied behaviour analysts. They suggest fading out services gradually based on the needs of the client (BHCE, n.d.). However, BHCE provide no evidence on which they base this recommendation.

Autism CRC's recent *National Guideline for supporting the learning, participation, and wellbeing of autistic children and their families in Australia* (Trembath et al, 2022), makes the following recommendations around duration of supports:

56.1 The amount and duration of support provision should be tailored to the individual needs of the child and family. This includes consideration of the frequency, length, and time of day of support sessions, and variations in support needs over time.

56.3 Practitioners should inform parents that there is no set number of hours per week of practitioner delivered child-directed supports that leads to the best outcomes for all children.

56.4 Practitioners should be aware that research evidence does not support the concept that supports delivered in greater amounts consistently lead to better child and family outcomes (Trembath et al, 2022, pp.95-96).

The *National Guideline* does not discuss reducing therapy over time.

6. Literature review table

The following papers were attached with the research request.

	Author / Date	Title	Study aim/objective	Relevance to Current Research Question	Quality of included evidence (high/medium/low/very low)
1	Camargo et al 2014	A review of the quality of behaviourally-based intervention research to improve social interaction skills of children with ASD in inclusive settings	Whether ABA improves social interactions for children with ASD; whether ABA can be considered evidence based.	Not relevant. Paper discusses behavioural components of some interventions for children with autism but does not discuss frequency/intensity of ABA or reducing therapy over time.	N/A
2	Steinbrenner et al 2020	Evidence-Based Practices for Children, Youth, and Young Adults with Autism Spectrum Disorder	Purpose of report is to “describe a set of practices that have clear evidence of positive effects with autistic children and youth”	Not relevant. Report discusses efficacy of multiple ABA programs but does not discuss frequency/intensity or timeframe of supports.	N/A
3	Kadar et al 2012	Evidence-based practice in occupational therapy services for children with autism	“identify how occupational therapy practice may have changed over the last decade and to explore what additional	Not relevant. Paper briefly mentions ‘behavioural approaches’ but does not discuss ABA,	N/A

	Author / Date	Title	Study aim/objective	Relevance to Current Research Question	Quality of included evidence (high/medium/low/very low)
		spectrum disorders in Victoria, Australia	developments are required in the field" to support children with ASD	reducing therapy over time or frequency/intensity of supports for children with autism.	
4	National Autism Center 2015	Findings and Conclusions: National Standards Project, Phase 2.	"provide up-to-date information on the effectiveness of a broad range of interventions for ASD"	Partially relevant. Paper discusses efficacy of behavioural approaches including interventions classed as ABA. Intensity and timeframe of therapy is discussed for Comprehensive Behavioral Treatment for Young Children (CBTYC), often described as ABA. CBTYC is described as an effective evidence-based practice but does not discuss whether the intensity or timeframe of the intervention is	N/A

	Author / Date	Title	Study aim/objective	Relevance to Current Research Question	Quality of included evidence (high/medium/low/very low)
				necessary to achieve benefits. Paper did not discuss reducing therapy supports over time Report states that intensity of therapy is a topic requiring further research and did not discuss frequency or intensity for other ABA therapies.	
5	Ivy & Schreck 2016	The Efficacy of ABA for Individuals with Autism Across the Lifespan	Editorial/narrative review regarding the efficacy of ABA across the lifespan for individuals with ASD.	Not relevant. Paper discusses efficacy of ABA but does not discuss frequency/intensity of therapy or reducing therapy over time.	N/A

7. References

- Behavioral Health Center of Excellence. (n.d.). *Suggestions for Ethically Fading Out ABA Services*. <https://www.bhcoe.org/2016/11/suggestions-ethically-fading-aba-services/>
- Camargo, S. P., Rispoli, M., Ganz, J., Hong, E. R., Davis, H., & Mason, R. (2014). A review of the quality of behaviorally-based intervention research to improve social interaction skills of children with ASD in inclusive settings. *Journal of autism and developmental disorders*, 44(9), 2096–2116. <https://doi.org/10.1007/s10803-014-2060-7>
- Ivy, J.W. & Schreck, K.A. (2016). The Efficacy of ABA for Individuals with Autism Across the Lifespan. *Current Developmental Disorder Reports*, 3, 57–66. <https://doi.org/10.1007/s40474-016-0070-1>
- Kadar, M., McDonald, R., & Lentin, P. (2012). Evidence-based practice in occupational therapy services for children with autism spectrum disorders in Victoria, Australia. *Australian occupational therapy journal*, 59(4), 284–293. <https://doi.org/10.1111/j.1440-1630.2012.01015.x>
- National Autism Center. (2015). *Findings and conclusions: National standards project, phase 2*. <https://www.nationalautismcenter.org/national-standards-project/phase-2/>
- Steinbrenner, J. R., Hume, K., Odom, S. L., Morin, K. L., Nowell, S. W., Tomaszewski, B., Szendrey, S., McIntyre, N. S., Yücesoy-Özkan, S., & Savage, M. N. (2020). *Evidence-based practices for children, youth, and young adults with Autism*. The University of North Carolina at Chapel Hill, Frank Porter Graham Child Development Institute, National Clearinghouse on Autism Evidence and Practice Review Team.



Research – Gemiini Program and Video Modelling: Evidence of Efficacy (Autism and other conditions)

Brief	Is there an evidence base to suggest that the Gemiini Program achieves the outcomes it purports?
	Gemiini systems refers to its program in the following way: “Gemiini is an online, on-demand program that’s been clinically proven to increase speech, language, reading, life skills & social skills for people with and without exceptionalities”
	Does it achieve these goals with anyone and everyone?
Date	December 2020
Requester(s)	Mathew [REDACTED] (Senior Technical Advisor – TAB)
Researcher	Craig [REDACTED] (Tactical Research Advisor – TAB/AAT)
Cleared	Jane [REDACTED] (Research Team Leader - TAB)
Cleared for external sharing	Deb [REDACTED] (Branch Manager – TAB) Date:

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The Research Team are unable to ensure that the information listed below provides an accurate & up-to-date snapshot of these matters.

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2 Summary

- Research into the efficacy of Video Modelling is substantial and there is evidence to support it as an evidence based practice
- The Gemiini System is a Video Modelling program and research into the system is very limited. On the basis of it being a Video Modelling system there is evidence to support it as an evidence based practice. However the system has distinguishing features which appear to take it beyond standard video modelling systems, and which require investigation.

3 What is Video Modelling (VM)?

Australia's Raising Children Network website [1] suggests VM is based on Albert Bandura's social learning theory, where according to the theory, people learn from each other by watching and copying. The site describes VM as a way to teach new skills or behaviour to autistic children, where the video shows someone doing a skill or behaviour, and the child watching the video copies the skill or behaviour. The site outlines four types of VM:

- **Basic VM:** this uses other adults, peers or animation as models.
- **Video self-modelling:** this uses the autistic child as the model.
- **Point of view VM:** this shows what completing the task would look like from the child's point of view. For example, the video shows a pair of hands doing a task.
- **Video-prompting:** this breaks up a task like brushing teeth into steps that the child watches as they complete the task.

4 What is the Gemiini Program?

4.1 Overview

The Gemiini System is a branded web based VM program. It targets two specific populations - individuals with **Autism** and individuals with **Down syndrome**.

The system can be accessed from a computer or tablet via the Gemiini internet web page, a mobile app, or the Gemiini [Roku](#) channel making it accessible from a television. No specially designed equipment/technology is required in order to use the system.



The following is a summary of how Gemiini Systems describes its program:

A web based program that uses a method called Discrete Video Modelling to teach speech and language skills, cognitive skills, academic skills, social and emotional skills, motor skills, activities of daily living, and more.

Video modelling is a form of observational learning in which new skills are acquired by watching a video of someone correctly demonstrating the targeted skills or behaviour.

Gemiini's unique method in filming and editing brings video modelling to new heights. The program uses a technique called Discrete Video Modelling (DVM). In DVM each video is designed to eliminate distracting sensory stimuli and distinct video clip types magnify and reinforce specific learning objectives.

DVM has been clinically proven to increase language, reading and social skills. Research has shown it to be more effective than Standard Video Modelling (SVM).

Gemiini Program clips includes three distinct ordered components:

- *Midshot*
- *Closeup*
- *Generalisation*

These components are sequenced together to create full clips for every topic in the Gemiini library. Full clips incorporate every aspect of DVM and are the most commonly used building block of Gemiini assignments. Gemiini offers more than 100, 000 DVM clips and the library is growing.

Gemiini users can make custom and individualised assignments. Teachers and therapists on the Gemiini team have used the library to build collections of pre made video therapy assignments targeting skills and dozens of areas. This allows for a quick click and play therapy for our users.

These pre made videos are automatically assigned to each students based on the results of a brief language assessment.

The Gemiini curriculum is organised according to a model of language development which makes it easier to deliver therapy even for individuals with limited access to resources [2, 3].

4.2 Alignment with Video Modelling

The creators of the Gemiini System assert that it is based on what is referred to as Discrete VM as opposed to Standard VM. Discrete VM appears to be a term coined by Laura Kasbar, the system creator. No other reference to the term could be sourced, and no reference to the term Standard VM could be sourced within what is known as VM.

It appears that the Gemiini System provides a technique in the way of delivering VM, which it refers to as Discrete VM. It incorporates the three distinct ordered components in the way the video clips are made, as outlined above, and is based on Discrete Trial Training (DTT).

DTT is a teaching technique used in some autism therapies. It isn't a therapy in itself. DTT is based on Applied Behaviour Analysis (ABA) theory. It involves breaking skills down to their most basic parts and teaching those skills to children, step by step. Children get rewards for all of their achievements, which encourages them to learn [4].

Sometimes called Discrete Trial Teaching, it is often used as part of a broad, ABA-based approach. It is typically used with autistic children aged 2-6 years, but it can be used with people of any age. It can be used to teach many new skills to autistic children which range from very simple to more complex, depending on the specific needs of the child. For example, DTT can be used to teach [4]:

- Speech and language skills, like those needed for having a conversation
- Skills needed for sign language or communication devices
- Daily living skills like dressing, using utensils and following instructions
- Writing skills

4.3 Promotion of funding via NDIS

Gemiini Systems, based in the USA, asserts via its website that they are partnering “with clinics throughout Australia.” The website makes no mention of partnering with other countries. On their website they promote Access Your Supports, a registered NDIS provider as “offering supported packages by their staff so recipients can maximize the benefits of Gemiini– all covered through NDIS” [5].

The Access Your Supports (AYS) website promotes the system and suggests that it “can be funded via your NDIS Plan.” The AYS website also asserts that the system “has the functionality of Vineland Adaptive Behaviour Scales (VABS) [6] embedded and outcomes measured each 3 months”, as this is “vital for your NDIS evidence and continued funding” [7]. Whilst the AYS website asserts this, the Vineland Adaptive Behaviour Scales as an outcome measure is not mentioned on the Gemiini Systems website.

To date, no other organisation or NDIS provider offering the Gemiini System could be sourced.

The Raising Children Network website indicates that it may be possible “to include the cost of using VM in children’s NDIS plans” [1]. The network is referring to VM (which is evidenced based) and not necessarily to the Gemiini System.

4.4 Outcome Measures

The AYS website asserts that the Gemiini program has the functionality of VABS embedded which provides outcome measures [7]. How the VABS is embedded in the program and how outcome measures are monitored could not be sourced.

The VABS has been a leading measure of personal and social skills needed for everyday living for over 30 years. Psychologists and other professionals continue to depend on the scales to identify individuals who have Intellectual and Developmental Disabilities, developmental delays, autism spectrum disorders, and other impairments. The VABS aids in diagnosis, and gives valuable information for developing educational and treatment plans [8].

The NDIS Quality and Safeguards Commission's guide for behaviour support practitioners [9], identifies the application of the VABS as being a tool with baseline and intermediate outcomes:

- Baseline tools: Initial one-off tools that are often used to identify and define problem behaviours and/or needs, and assist in the development of behaviour support plans.
- Intermediate tools: Pre- and post-intervention tools that measure change or progress regarding identified behaviours within behaviour support plans.

The guide identifies the administration qualification of the tool as:

- B User Level Qualification - Allied Health or Special Education Professional. This applies to, but is not limited to those with an undergraduate and/or Master’s degrees in speech pathology, occupational therapy, physiotherapy and may include special education, medical and behavioural science.

5 Video Modelling as an Intervention

The major research report by Autism CRC, commissioned by the NDIA, “Interventions for children on the autism spectrum: A synthesis of research evidence” [10], suggests there is a variety of terminology which have been used to describe interventions for children on the autism spectrum.

For example, therapy, treatment, intervention, support, approach, program, practice, technique and strategy are often used interchangeably across disciplines (e.g., allied health, medical, education) and also by individual caregivers, clinical practitioners, educators and researchers.

The report uses the term “intervention” to denote a collection of clinical techniques, applied in combination, which aims to support the acquisition of developmental or educational skills, in order to promote well-being and community participation. The report classifies intervention activities into three levels, ranging from the **intervention techniques** that combine to form **intervention practices**, which are in turn grouped together under the broader term of **intervention categories**. Definitions of these are in the table below.

Term	Description	Examples
Category	One or more practices that share similar theoretical underpinnings.	Behavioural interventions
Practice	A combination of techniques evaluated and implemented together to target the acquisition of one or more skills.	Early Intensive Behavioural Intervention, Discrete Trial Training, the Picture Exchange Communication System
Technique	A discrete clinical strategy, targeting the acquisition of a discrete skill.	Prompting, modelling, shaping, reinforcement

The report maintains a focus on interventions for children on the autism spectrum at the practice and category levels. It excludes "techniques" as a focus of the review, due to the aim of the report which is "summarising the evidence base for the therapeutic and other effects of interventions – and a clinical understanding that the application of a single technique in isolation is unlikely to be sufficient to support the needs of children who, based on contemporary diagnostic criteria, have pervasive needs across multiple developmental domains".

In the consensus on intervention eligibility for the literature review, the report did not acknowledge VM as an intervention but rather a "technique".

Similarly, a major research report partly funded by the United States Department of Education, Office of Special Education Programs [11], and quoted by the NDIS in their autism evidence based good practice for supports report [12], makes a distinction between “comprehensive treatment models” and “focused intervention practices”. Comprehensive treatment models consist of a set of practices designed to achieve a broad learning or developmental impact on the core deficits of ASD. In contrast, focused intervention practices are designed to address a single skill or goal of a student with ASD. Examples include discrete trial teaching, pivotal response training, prompting, and VM.

5.1 Delivering Video Modelling by professionals within their scope of practice

The Autism CRC report [10] rates the delivery of Video Monitoring by professionals as "Pathway 2". This pathway relates to intervention techniques and practices that can be ethically delivered by a range of professionals within their scope of practice, without requiring any formal training beyond that required for professional registration. There is no formal accreditation required to use these techniques and practices, and they can include approaches that are broadly relevant to supporting

children's development in general (e.g., emergent literacy instruction) as well as to children with a range of neurodevelopmental conditions. Examples of techniques and practices that are not specific to a particular discipline and do not require any further formal training, include naturalistic teaching strategies, reinforcement, incidental teaching, social stories, and **VM**.

6 Efficacy of Video Modelling as a technique

There is a plethora of literature which supports the use of VM as an evidence based practice. The research evidence has predominantly investigated its use in those with autism, however, other conditions such as Down syndrome and developmental disabilities have also been explored.

Efficacy research on VM as an instructional approach for individuals with autism has been found to be a promising area for teachers and researchers. Over the last three decades the literature has shown successful use of VM for teaching a variety of social, academic, and functional skills [13].

VM is a well-validated behavioural intervention utilised in the behavioural sciences that has been developed to facilitate observational learning [14]. It has been used successfully to train skills as diverse as parent training for conduct disorder children [15], social skills in children with social deficits [14], and instruction for speech therapists [16].

The major evidence-based practices review [11] mentioned earlier, included 456 studies in its review which were published in peer reviewed, English language journals between 1990 and 2011 and tested the efficacy of focused intervention practices.

The review found the following:

- **Qualifying Evidence:** VM meets evidence-based criteria with 1 group design and 31 single case design studies.
- **Ages:** According to the evidence-based studies, this intervention has been effective for toddlers (0-2 years) to young adults (19–22) years with ASD.
- **Outcomes:** VM can be used effectively to address social, communication, behaviour, joint attention, play, cognitive, school-readiness, academic, motor, adaptive, and vocational skills.
- **Research Studies Providing Evidence:** The review cited 32 studies (page 101) [11]

Although the majority of the literature has focused on VM for autism, various case studies have investigated its use to increase physical activity, dietary habits, and weight lifting learning in those with Down syndrome.

A 2015 study looked at VM to assist physical activity targeting in three preschool children with Down syndrome [17]. Two preschool children without disabilities participated by providing the video models before study conditions began. Six randomly selected children without disabilities participated as comparison peers for the purposes of social validity. An ABAB research design was used to determine if interventions were effective in changing the behaviour of participants. Results showed increases in moderate to-vigorous physical activity for all children during the intervention.

A 2018 study [18] examined the effectiveness of video hero modelling and praising (VHMP), for improving the transition-related behaviours of two elementary-aged students with Down syndrome. Each participant watched a video in which appropriate transition-related behaviours were exhibited side by side with the hero in the setting where the target behaviours were expected to occur. In addition, the hero praised the student for exhibiting the target behaviours in the video. A multiple baseline across- settings design was utilised for one student and an AB design for the other to determine if VHMP contributed to their behaviour change. Results showed that their transition-related behaviours dramatically improved immediately after VHMP was introduced.

A 2017 study investigated the effects of VM on dietary habits and weight of patients with Down syndrome [19]. Participants were recruited if interested in losing weight, and had access to a smartphone. A quasi-experimental design was used for the study. Three 7-day food records, height, weight, and patient/caregiver satisfaction surveys were collected from six participants (age 26-35 years) involved in the VM intervention. Weight data were compared between intervention participants and six control participants (age 24-37 years) who received only verbal nutrition counselling. Results indicated mean kilocalorie, protein, and fat intakes significantly decreased from baseline to 2 months ($p=.013$, $.010$, $.022$, respectively). Feedback from surveys confirmed patients enjoyed watching the videos and caregivers were highly satisfied with participation. Results of the study were optimistic in that patients were eating significantly fewer calories post intervention, which over time could result in weight loss.

Considering that strength decreases with age resulting in difficulty performing activities of daily living for adults with Down syndrome, a 2018 study set out to determine whether the use of VM is appropriate for teaching adults with Down syndrome to perform weight lifting techniques [20]. Three adult males (24 to 34 years) with Down syndrome participated in the study. A certified U.S. weight lifting coach completed a task analysis for split squat (SS), punch-out squat (POS), and overhead press (OP). For baseline measures participants watched a demonstration of each lift and were then recorded performing the lift. Once baseline measures became stable, participants viewed a video of a model using correct lifting technique three times. They were then video recorded performing the lift. Participants were least successful with the SS averaging 16% correct at baseline and 36% correct after viewing the videos. POS went from 50% correct to 87%; OP started at 42% and increased to 80% correct movement. The VM intervention alone was not sufficient to produce an effective outcome across all lifts, but did help participants acquire more components of each lift.

7 Efficacy of the Gemiini System as a technique

In identifying VM as an established evidence based intervention, efficacy of the Gemiini system needs to be looked at with regard to its assertion of its strengths in being a Discrete VM system, and the functionality of the VABS as an outcome measure.

Three studies could be sourced with a focus on the Gemiini system.

A 2015 study [21] evaluated the effectiveness of two VM programs to teach expressive vocabulary words to individuals with autism and other disorders, by comparing the Gemiini as a Discrete VM system, and Teach2talk™ [22] as a Standard VM system. The results showed a significant increase ($p 0.03$) in expressive words with the Gemiini discrete VM program. The participants in the study were 31 students in preschool, kindergarten, first, second, third, and fourth grade classes at an inner city

school. The majority of students were diagnosed with autism (58% of the population), followed by health impaired (16.1%), Down syndrome (9.7%), specific learning disability (9.7%), and emotional disorder (6.5%).

The researchers collected data across four classrooms in a school district in Inglewood, California, in a double-blind study across three weeks. During Week 1, baseline data were collected across two sets of targets presented in each VM program. During Week 2, the instructors showed the standard VM program to half of the classrooms, while instructors for the other half of the classes showed the discrete VM program. During Week 3, the instructors switched the VM programs with the two groups to compare the language acquisition outcomes. The researchers collected data on all targets at the end of each week's viewings. Comparing the two programs using chi-square tests of independence.

Another 2015 [23] case study examined the effectiveness of VM to facilitate the development of word recognition and pronunciation in three male high school students with ASD, using videos selected from the Gemiini system library to address each student's unique needs, where classroom teachers identified those needs. A single-case multiple baseline experimental design across participants (i.e. VM sequentially implemented across three students) was used. Baseline data collection consisted of testing the students' word pronunciation and recognition of the target words. The intervention phase consisted of students watching videos for each target word 10 times per session, which took approximately 15 minutes. At the end of each session, students' knowledge of target words was tested. To assess maintenance of gains for participants, follow-up measurements were conducted three months after the completion of the intervention and were identical to measurements taken during the video modelling intervention.

All three participants improved and maintained accuracy scores during the follow-up phase as compared to the baseline phase for both target behaviours. The study found that the results were consistent with previous research they found that demonstrated the effectiveness of VM for use in individuals with ASD.

The study has several limitations that should be noted.

- 1) VM was not compared to other intervention models of instruction. Therefore more research is needed to ascertain whether VM is more or less effective than other methods for the education of adolescents with ASD
- 2) Findings are unlikely to be generalizable due to the small sample size and single-case design
- 3) Methods used to collect accuracy scores may have impacted the effects of the intervention

In 2015 the Wisconsin Department of Health Services, Treatment and Advisory Committee, reviewed the Gemiini system in order to determine whether or not it views the system as a proven and effective treatment for children with ASD and/or other developmental disabilities [24]. After reviewing the research on VM and the Gemiini system, the Department concluded that "the Gemiini system is a Level 1 - Well established/Strong Evidence practice and a proven and effective treatment". However, it needs to be noted that the committee reviewed VM research within autism and Down syndrome cohorts and not Gemiini system specific studies.

8 Conclusions

8.1 Evidence of Efficacy

Although research specific to the Gemiini System is scarce, it is based on the significant research into VM which appears to meet evidence based practice. The two distinguishing features of the Gemiini system, Discrete VM based on Discrete Trial Training, and the embedding of VABS into the system, both appear to be evidence based practices. However, how VABS is used in the Gemiini System to measure outcomes could not be sourced.

8.2 Video Modelling & Gemiini System as a Technique

There is a variety of terminology which can be used to describe interventions for those on the autism spectrum and those with similar behavioural issues. The Gemiini System should be interpreted as a “technique” which is applied in combination with other interventions, and aims to support the acquisition of developmental or educational skills, in order to promote well-being and community participation. This is supported by:

- Autism CRC: Interventions for children on the autism spectrum: A synthesis of research evidence [10]
- Evidence-based practices for children, youth, and young adults with Autism Spectrum Disorder [11]
- Autism spectrum disorder: Evidence-based/evidence-informed good practice for supports provided to preschool children, their families and carers [12]

8.3 Delivery and Administration of the Gemiini System

The administration and delivery of the Gemiini System as a VM technique can be delivered by a range of professionals within their scope of practice, without requiring any formal training beyond that required for professional registration. This is supported by:

- Autism CRC: Interventions for children on the autism spectrum: A synthesis of research evidence [10]

In terms of the delivery of the Gemiini system, if the validity of VABS imbedded in the system is taken into account, it should be administered by an allied health or special education professional. This applies to, but is not limited to those with an undergraduate and/or Master’s degrees in speech pathology, occupational therapy, physiotherapy and may include special education, medical and behavioural science. This is supported by:

- NDIS Quality and Safeguards Commission's guide for behaviour support practitioners [9]

9 Recommendations

- Whilst VM is an evidence based practice and is the fundamental technique used by Gemiini System, TAB Advisors should be aware that it is a technique which can be delivered by a range of professionals within their scope of practice, when providing capacity building supports.
- The Gemiini System website and the Access Your Supports (AYS) website both make reference to AYS being able to offer supported packages which are covered by the NDIS. As this is a broad statement, it may be misinterpreted by participants. The NDIS may want to investigate this further.

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Sexual services and sexualised behaviours of concern

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Please note:

The research and literature reviews collated by our TAB Research Team are not to be shared external to the Branch. These are for internal TAB use only and are intended to assist our advisors with their reasonable and necessary decision-making.

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The Research Team are unable to ensure that the information listed below provides an accurate & up-to-date snapshot of these matters

Research question: Can sexual services delivered by a sex worker reduce the frequency or severity of sexualised behaviours of concern (including aggressive, inappropriate or offensive sexual behaviour, sexual assault, sexual harassment or other criminal behaviour of a sexual nature) for people with disability?

Date: 09/12/2022

Requestor: Steve s47F - personal privacy

Endorsed by: Katrin s47F - personal privacy

Researcher: Aaron s47F - personal privacy

Cleared by: Stephanie s47F - personal privacy

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2. Summary

This paper discusses evidence for sexual services as an intervention to reduce sexualised behaviours of concern. There is little evidence in the literature supporting a specific strategy to reduce sexualised behaviours of concern. Much of the evidence is derived from single subject case studies which do not generalise.

There is one study that explicitly identifies sex work as an intervention that can reduce behaviours of concern. In this study, utilisation of a sex worker coincided with near complete reduction in instances of sexualised behaviours of concern. However, since the study was a single subject case study, it is not possible to generalise the results ([3. Case study](#)).

There is some further evidence, mostly theoretical and anecdotal, that assisting people with disabilities to engage in intimate relationships or otherwise exercise their sexual expression might lead to a reduction in behaviours of concern ([4. Facilitated sex](#)).

This paper also discusses other ways of managing inappropriate sexualised behaviours. The weight of evidence is in favour of behaviour analytic methods, especially interventions using differential reinforcement or multi-component behaviour modification ([5. Other interventions](#)).

3. Case study – sex work used to reduce sexualised behaviours of concern

There is a single study which examines the use of sex work as an intervention intended to manage sexualised behaviours of concern (Kelly & Simpson, 2011). The subject was a single man in his 40s who experienced a hypoxic brain injury 5 years prior. The subject showed behaviours of concern including inappropriate sexual talk, genital and non-genital touching, public masturbation and exhibitionism. The authors note that the initial preference for their intervention was sexual surrogacy (refer to [4. Facilitated Sex](#)). No surrogate partners were

available in the subject's location and so the treating team investigated accessing a sex worker instead.

The study employed a BCBC design in which the baseline condition and comparison condition were alternated over a period of months. The baseline condition involved consistent behaviour management including avoiding triggers, redirection, prompting to act appropriately or removing subject or target from the situation. The comparison condition involved consistent behaviour management plus weekly or fortnightly visits to a sex worker. Numbers of incidents of sexualised behaviours of concern began to reduce from the second half of the first baseline phase. Incidents of inappropriate sexual talk occurred over 49 times in the first baseline phase. This reduced to 16 times in the first comparison phase, remained steady in the second baseline phase (17 times) and then reduced to 2 times in the last comparison phase.

The first comparison phase saw dramatic reductions in inappropriate sexual touching and exhibition. Incidents of exhibitionism and public masturbation occurred 14 times in the first baseline phase, twice in the second baseline phase and did not occur at all in the either of the comparison phases. Incidents of inappropriate touch occurred 23 times in the first baseline phase, twice in the first comparison phase, 3 times in the second baseline phase and did not occur at all in the last comparison phase (refer to *Figure 1 - Incidents of sexualised behaviours of concern by shift*).

Reduction in behaviours may have been due to the combination of consistent behaviour management and visits to a sex worker. As the reduction was seen from the second half of the first phase, the main therapeutic effect may be due to the behaviour management techniques. In a related study, Kelly et al (2022) reflect on this case study and suggest that the effects are likely due to the ongoing value of behaviour supports implemented for the duration of the study. Also, the reduction may be partially due to the support workers becoming more comfortable and skilled at employing behaviour management techniques over time.

While this case study suggests a strong effect of the intervention, it examined only a single person and so results cannot be generalised beyond this study. Unfortunately, no further studies have re-examined the hypothesis. It should also be noted that systematic reviews which included Kelly and Simpson (2011) rate the study of moderate to high quality (Clay et al 2018; Verberne et al 2019).

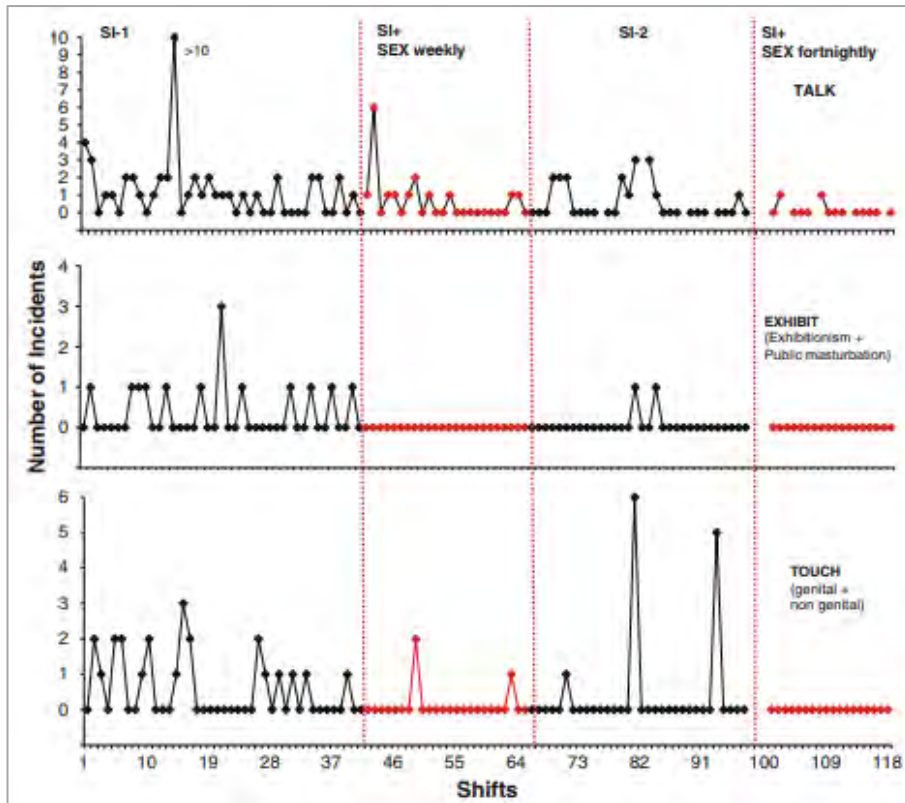


Figure 1 Incidents of sexualised behaviours of concern by shift

4. Facilitated sex

The intervention used in Kelly and Simpson is a type of facilitated sex. Facilitated sex refers to a variety of activities that address the sexual needs of people with disabilities (Kelly & Simpson, 2011). This can include sexual health education, assistance to attend social events, assistance obtaining services of a sex worker, obtaining or acting as a surrogate partner, set up, preparation or physical assistance to initiate masturbation or sex (Earle, 2001; Bahner, 2016). There is some lack of consensus around terminology. For example, Benoit et al (2022) reproduce a distinction in the literature between sexual assistance and facilitated sexual assistance. The latter term is broader and covers all the activities described as sexual assistance.

There are theoretical reasons for thinking that facilitated sex might lead to a reduction in behaviours of concern. One approach suggests that some inappropriate sexual behaviour could be a result of a lack of skills or opportunity to form functional intimate relationships (Grace et al, 2020). There is some support for this in a study of self-reported motivations for criminal sexual behaviour among people with ASD. Subjects in this study reported some motivations for inappropriate sexual behaviour to be lack of understanding of appropriate relationships, lack of social skills to aid in forming relationships, lack of any intimate relationships or simply wanting to have sex (Payne et al, 2020).

Reyes et al (2011; Falligrant & Pence, 2020) describe a study in which inappropriate sexual behaviours are replaced with appropriate sexual behaviours:

Masturbation decreased subsequent arousal to deviant stimuli, suggesting masturbation may decrease arousal levels in situations where an establishing operation for inappropriate sexual behavior is typically present. Self-management procedures may be enhanced by teaching individuals with IDD to masturbate prior to engaging in activities or entering situations that are typically arousing. That is, just as these individuals may learn to inhibit or manage their arousal by counting backwards, they may also learn to engage in appropriate sexual behavior as an antecedent strategy to reduce subsequent arousal. (Faligrant and Pence, 2020, p.3)

Victorian state government guidelines support this approach for young people with intellectual disability or ASD. They suggest providing the young person with “time alone with privacy” and encouraging behaviour change “through safe and fulfilling sexual exploration” (Department of Health and Human Services, 2016, p.10).

Besides Kelly and Simpson (2011) and Reyes et al (2011) no other studies were found that explicitly aim to investigate the effect of facilitated sex on inappropriate sexualised behaviours. However, some studies mention an observed effect. These observations are largely anecdotal. For example, in an interview study of nurses and clinicians in an aged care setting, Watershoot et al note that participants described a reduction in inappropriate sexualised behaviours for a person with dementia after introducing a specialised sex worker:

some participants described how their team learned how to facilitate the residents in a pro-active manner over time. N5 described this a “win/win” situation, for example, because hiring a specialized sex worker let a resident “bloom” and decreased a resident’s inappropriate touches toward staff as well (Watershoot et al, 2022, p.840).

Torrise et al (2017) and De Geogi and Series (2016) agree that facilitating sex for people with dementia and reinterpreting sexualised behaviours as the expression of a need for intimacy might help reduce behaviours of concern:

The need for normal sexual expression while preventing inappropriate sexual behaviors should be emphasized. In nursing homes, single rooms and provision for conjugal or home visits could help reduce the frequency of such behaviors by satisfying the patient’s normal sexual drive (Torrise et al, 2016, p.5).

Similarly, Aloni et al (2007) present a case study of surrogate partner therapy in which a 22-year-old man with a TBI was assisted to access a surrogate partner. Surrogate partner therapy is a form of therapy in which a client works with both a therapist and a surrogate partner to practice social and relationship skills in a controlled environment. This can include exercises in relaxation, communication, sensual and sexual touching (IPSA, n.d; Benoit et al, 2022). The intervention was motivated, in part, by inappropriate sexualised behaviours of concern. Aloni et al report that the subject’s “inappropriate way of talking and sexual behaviour was reduced and at times was almost eradicated” (Aloni et al, 2007, p.132). However they did not report any other relevant details of this change nor does the study appear to have an experimental design. Also of note, while surrogate partner therapy is intended to treat a variety of issues

related to intimacy, relationships and sexual health, there is no indication that the therapy is intended to address sexualised behaviours of concern or inappropriate sexual conduct (IPSA, n.d; Frickelton, 2013; Rosenbaum et al, 2014).

5. Other interventions for sexualised behaviours of concern

It can be difficult to structure experimental studies with adequate sample sizes which examine the effects of treatments on sexualised behaviours of concern. This can be due to ethical considerations or lack of available participants (Casey et al, 2018). Much of the research is structured around single participant case studies. This is true of research focussing on young people and adults.

In their systematic review, Casey et al (2018) conclude that there is insufficient evidence to determine which specific technique is most effective at reducing inappropriate sexualised behaviours for people with acquired brain injury, intellectual or developmental disability. However, the strongest evidence was for behaviour analytic techniques using either a punishment component or a differential reinforcement component or both.

A narrative review from Warner et al (2022) suggests that Applied Behaviour Analysis (ABA) can assist with the management of sexualised behaviours of concern in people with Autism Spectrum Disorder. However, due to the format of the review, the quality and levels of evidence of included studies was not considered. Also, recommendations were largely based on the generalisation of ABA techniques to sexualised behaviours rather than direct evidence of efficacy. For further information on ABA used to manage behaviours of concern please refer to TAB research paper [RES 246 ABA and positive behaviour support.docx](#).

Pritchard et al (2016) describe a case of reducing significant and problematic sexual behaviours of concern in a 17 year old with ASD using an individualised multi-component behavioural intervention. Intervention included cognitive behavioural therapy, sexuality and relationship education, active support and a points-and-levels behaviour modification system. At conclusion of the study the subject had not shown sexualised behaviours of concern for 3 months. The authors followed up with Pritchard et al (2021) in which they describe several cases of individualised multi-component behavioural intervention showing consistent success in reducing behaviours.

Falligrant and Pence (2020) describe different procedures of differential reinforcement of alternate behaviour or differential reinforcement of other behaviour, sometimes combined with punishment, for people with intellectual and development disability. All the interventions they canvassed were effective at reducing sexualised behaviours of concern, sometimes to near zero levels. They also describe some studies indicating people with intellectual and development disabilities may be able to learn self-management methods to reduce behaviours. However, all the studies described are either single person case studies or very low sample studies. The authors do not consider quality or levels of evidence in their review.

In patients with dementia, Torrisi et al (2017) recommend certain behavioural interventions including redirection, distraction and avoidance of triggers. This is supported by De Georgi and Series (2016) who also note that despite lack of empirical evidence, non-pharmacological treatments for sexualised behaviours of concern are the first line treatment for inappropriate sexualised behaviours due to issues of safety and ethics.

A handful of studies have focused on inappropriate sexualised behaviours for young people with autism or developmental disabilities. McClay et al (2015) found 11 studies showing positive treatment effects of interventions for reducing inappropriate sexualised behaviour in children and adolescents with developmental disabilities. Most studies support behaviour analytic techniques such as differential reinforcement but most studies are also single subject case studies and so results are not generalisable.

Clionsky and N'Zi (2020) assert that there are no evidence-based interventions for children or adolescents with ASD showing inappropriate sexualised behaviours. They suggest that effective treatments for neuro-typical young people, such as cognitive behavioural therapy, should be adapted for children and adolescents with ASD. However, this suggestion contrasts with a 2020 Cochrane Review, which found insufficient evidence to determine whether cognitive behavioural therapy was effective for reducing harmful sexual behaviour in adolescents without disability (Sneddon et al, 2020).

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Home and living supports for people with dementia

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Research questions:

What are the most appropriate living environments to support people with dementia to live safely and with as much independence as possible?

What are the best practice strategies to address behaviours of concern for people living with dementia?

What are the benefits or risks to people with dementia to live in their home vs in a dementia care facility?

Date: 9/1/2025

Requestor: Shannon s47F - personal priv

Endorsed by: n/a

Researcher: Aaron s47F - personal privacy

Cleared by: Aaron s47F - personal privacy

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2. Summary

This paper considers home and living support models for people with dementia. Three general models are considered: living at home, living in supported accommodation, and living in a Residential Aged Care facility.

Most people with dementia choose to remain living at home for as long as possible. Supports to remain living at home also feature in many government support strategies and advocacy initiatives. Familiar environments and routines, autonomy and choice and control often feature in decisions to remain living at home.

It is not possible to determine the best possible model of support as people living with dementia have different needs and preferences that might be met best by different models of care at different times. In addition, each model can be organised in different ways to maximise beneficial characteristics. For example, it is widely agreed within the literature that incorporating familiar homelike features into any accommodation option will improve outcomes for residents. However, it is not possible to say with certainty that this will apply across all accommodation models due to the quality and design of the studies considered and the complexity of the intervention.

It is not possible to determine which accommodation model is associated with the best outcomes due to the quality and design of studies considered and the complexity of the intervention.

This paper also considers behaviour support for people with dementia. There is general agreement that an approach based on the principles of positive behaviour support will have the best and most equitable outcomes for people with dementia.

3. Living with dementia in Australia

In 2024 there were an estimated 421,121 people living with dementia in Australia. Almost 29,000 of those are under 64 years (AIHW, 2024b). In 2024, approximately 4,203 NDIS participants had reported a diagnosis of some kind of dementia (NDIA, 2024a).

Most people with dementia are living in the community. Older people are more likely to be living in residential care facilities. 2022 AIHW estimates place almost all of those aged under 65 years are living in the community. By 79 years, this reduced to three-quarters and by 90+ years, half of those living with dementia were still living in the community (AIHW, 2024).

Older data from 2012 suggests 95% of those with younger onset dementia were living in the community when they first started receiving treatment. Within 5 years after first receiving treatment, 42% were still living in the community, 31% had moved to residential aged care and 27% had died (AIHW, 2022).

4. Outcomes associated with living arrangements

This section considers the risks and benefits of people with dementia living at home, in supported accommodation or in a Residential Aged Care facility. It also considers a feature of multiple accommodation and support models: the integration of homelike features.

4.1 Living at home

Most sources recommend supporting people with dementia to continue living at home as long as possible (Loi et al, 2023; Hellis & Mukaetova-Ladinska, 2023; Social Care Institute for Excellence, 2021; Smith et al, 2021; Faulkner et al, 2015). Moving from home into supported accommodation or a residential care facility:

can be experienced as a loss of independence for people living with dementia, and associated with feelings of guilt by family carers, particularly when this decision is made on behalf of the individual. Consequently, moving out of home can be seen as a last resort for people affected by dementia, when other sources of support no longer work (Levertton & Pui Kin Kur, 2023, p.1).

4.1.1 Benefits

Most people choose to remain living at home as long as possible to maintain their autonomy and preserve existing relationships and routines. Remaining at home can also delay or prevent stressful transitions to other care arrangements which can be emotionally and cognitively demanding on people with dementia (Faulkner et al, 2015; Dementia Support Australia, n.d.). Living at home may be correlated with increased quality of life for people with dementia (Loi et al, 2023; Hellis & Mukaetova-Ladinska, 2023).

4.1.2 Risks

There are risks to psychological and physical health and safety when remaining at home compared to transitioning into residential facility. Less accessible environments may lead to increased risk of falls (Bowes et al, 2024b). Some evidence suggests people living with dementia in the community are at risk of having unmet health and social care needs (Smith et al, 2021).

Well-designed home environments may mitigate some risks of living at home and promote quality of life for people with dementia and their family and carers (Bowes et al, 2024; Dementia Australia, 2022). Dementia Australia offers guidelines for dementia-friendly design within the home, including:

- Choose brighter lightbulbs and place chairs or tables close to windows or sunlit areas.
- Maintain clear pathways and open spaces by reducing clutter and removing tripping or slipping hazards.
- Display personal items and photos.
- Place regularly used items in your line of sight
- Use labels or picture cards to help locate and identify items (e.g. label hot and cold taps).
- If appliances need to be replaced, opt for similar models that operate in the same way.
- Use distinctive coloured doors and contrasting door frames to help with orientation (Dementia Australia, 2022).

Research supports long term planning of home design to implement changes in routine and home modifications in anticipation of their need (Bowes et al, 2024b). In addition, support for family and carers of people with dementia can assist them to remain living at home longer. There is evidence that behavioural and psychological symptoms of dementia have a substantial impact on the carer fatigue and can contribute to early transition to a residential facility. Addressing behavioural and psychological symptoms may extend the time in which people with dementia can remain living at home (Bowes et al, 2024b). Refer to [5. Behaviour support](#) for further details.

4.2 Living in supported accommodation

Supported housing models for people with dementia include group homes, supported independent living and other housing models which integrate care and accommodation while enabling those with dementia to live as independently as possible in the community (Oakley & Atkinson, 2024; Smith et al, 2021).

4.2.1 Benefits

There is evidence that supported accommodation “can improve quality of life, increase independence and autonomy, combat social isolation, reduce hospitalisations and defer entry into residential care for people with dementia” (Smith et al, 2021, p.590). Other advantages include the ability to customise care and vary the model to suit the residents (Oakley & Atkinson, 2024).

4.2.2 Risks

The benefits of supported accommodation models may be negatively affected by resourcing issues including staff ratios and staff training needs. Depending on the specific house, residents may not be able to choose their room-mates and there is the potential for residents with widely varying support needs to be placed in a single home (Oakley & Atkinson, 2024; Smith et al, 2021). A review of qualitative studies found that:

a diagnosis of dementia may become a barrier to living independently and autonomously in supported housing, with people referred out of the settings as their condition progressed and care needs increased. A lack of resources, including low staff numbers, limited/no staff training in dementia and dementia care and limitations in the physical environment appeared to be the main reasons for this (Smith et al, 2021, p.601).

4.3 Living in Residential Aged Care

This section considers residential aged care models of support broadly construed. However, there are various ways of organising residential aged care facilities that may have different benefits and risks (Harrison et al, 2022). Refer to [4.4 Living in a homelike environment](#) for more information.

4.3.1 Benefits

One reason for transitioning to aged care for people with dementia is access to a higher level of care, including better access to health services (National Seniors Australia, 2023). 2022 data shows those with dementia who enter residential aged care after a hospital stay are less likely to be readmitted within a year compared to those who remain living in the community (AIHW, 2022). However, 2018 data shows that although older people with dementia are likely to have more health complications than older people without dementia, there is less total expenditure on health services for older people with dementia living in residential aged care (Gnanamanickam et al, 2018). 2022 data shows those with younger onset dementia in residential aged care have fewer GP and specialist appointments compared to those living in the community (AIHW, 2022).

4.3.2 Risks

AIHW’s 2022 *Younger onset dementia* report states that compared to those living in the community, people with younger onset dementia in residential aged care:

- are likely to be assessed as needing high levels of care in at least 3 domains of the Aged Care Funding Instrument when first entering residential aged care
- are more likely to die within 5 years of first receiving treatment
- are 4 times more likely to have an overnight hospital stay for dementia
- have fewer GP and specialist appointments
- are more likely to be prescribed anti-psychotic medications
- are more likely to be prescribed 5 or more medications (polypharmacy) (AIHW, 2022).

4.4 Living in a homelike environment

Some of the reported benefits of remaining at home may be achieved in a more formal living arrangement by incorporating homelike features into the care environment. A 2018 study of 17 Australian residential aged care facilities found improved quality of life, fewer hospitalisations and fewer emergency room presentations for residents when the model of care included homelike features including:

- fewer residents
- meals cooked in the unit
- participation in domestic duties
- access to outdoor spaces (Dyer et al, 2018).

Of note, 98% of residents in more homelike models of care had a diagnosis of dementia (Dyer et al, 2018). An earlier scoping review also found evidence that more homelike models of residential care are associated with improved physical functioning of residents in dementia-specific accommodation (Ausserhoffer et al, 2016).

Some evidence suggests incorporating features of homelike environments in other accommodation settings (such as supported accommodation or residential facilities) can reduce behavioural and psychological symptoms of dementia, improve quality of life and reduce medication use (Vlotinou et al, 2023). For a discussion of homeliness as it relates to autonomy and behaviours of concern for people with dementia, refer to [RES 296 Home modifications and behaviours of concern](#).

However, due to the complexity of the intervention being measured, it is difficult to draw precise conclusions. A 2022 Cochrane review found inconsistent evidence around the effectiveness of homelike models of care:

There is currently insufficient evidence on which to draw conclusions about the impact of physical environment design changes for older people living in residential aged care. Outcomes directly associated with the design of the built environment in a supported setting are difficult to isolate from other influences such as health changes of the

residents, changes to care practices over time or different staff providing care across shifts (Harrison et al, 2022, p.2).

5. Behaviour support

Challenging behaviours can impact the home and living supports available for people with dementia. Behavioural and psychological symptoms of dementia can increase the difficulty informal caregivers experience providing care (Delfino et al, 2021). For people with younger onset dementia, behaviours can lead to early entry into residential aged care or to frequent moves between aged care services, disability support services and health services (Loi et al, 2023; Delfino et al, 2021; Cloutier et al, 2019). In addition, provision of inappropriate care can exacerbate behavioural symptoms of dementia (NICE, 2018).

Non-pharmacological approaches are the first line strategy for addressing behaviours of concern (Loi et al, 2023; Alzheimer's Society, 2021; Scharre, 2021; NICE, 2018). Non-pharmacological approaches usually employ a positive behaviour support framework in which behaviours are identified in the context of the person's environment, health and personal preferences before strategies are identified to manage the behaviours (Serrano et al, 2024; Loi et al, 2023; Vlotinou et al, 2023; Scharre, 2021; Williams et al, 2019; NICE, 2018). Strategies that may be effective in reducing behaviours of concern include: staff training in behaviour support, person-centred strategies, participation in activities of interest, environmental modifications promoting homelike qualities and comfort (Vlotinou et al, 2023; Profyri et al, 2022; Scharre, 2021; Bridge and Vasilacopolou, 2019; NICE, 2018).

The 2018 NICE guideline on the treatment of dementia found residential centres offering staff training in behavioural intervention had reduced levels of anxiety and verbally aggressive behaviours but no statistically significant reduction in physically aggressive behaviours (NICE, 2018). A recent observational study of over 500 residential care facility residents with dementia found medication prescription to manage behaviour reduced significantly after the introduction of communication skills training for staff (Kobayashi et al, 2024).

Recommendations from the NICE guideline include:

91. Before starting non-pharmacological or pharmacological treatment for distress in people living with dementia, conduct a structured assessment to:

- explore possible reasons for the person's distress and
- check for and address clinical or environmental causes (for example
- pain, delirium or inappropriate care).

92. As initial and ongoing management, offer psychosocial and environmental interventions to reduce distress in people living with dementia.

93. Only offer antipsychotics for people living with dementia who are either:

- at risk of harming themselves or others or

- experiencing agitation, hallucinations or delusions that are causing them severe distress...

96. When using antipsychotics:

- use the lowest effective dose and use them for the shortest possible time
- reassess the person at least every 6 weeks, to check whether they still need medication.

97. Stop treatment with antipsychotics:

- the person is not getting a clear ongoing benefit from taking them and
- after discussion with the person taking them and their family members or carers (as appropriate).

98. Ensure that people living with dementia can continue to access psychosocial and environmental interventions for distress while they are taking antipsychotics and after they have stopped taking them.

99. For people living with dementia who experience agitation or aggression, offer personalised activities to promote engagement, pleasure and interest (NICE, 2018, pp.329-330).

6. Other Resources

The Australian Institute of Health and Welfare has recently published the 2024 [Dementia in Australia](#) report, which includes general statistical information and demographics about Australian with dementia, their family and carers and the community.

Dementia Australia has a number of useful resources relating to home and living supports for people with dementia. These include reports, case studies, library guides, and an app to assist people with dementia to design their home environment:

- [Library Guide – Home environment and dementia](#)
- [Library Guide – Dementia friendly communities](#)
- [The Dementia-Friendly Home app](#)
- [The Dementia Guide](#)

The [2020 World Alzheimer's Report](#) published by [Alzheimer's Disease International](#) focuses on issues in dementia-related design and the built environment:

- [Volume 1](#) focuses on research, policy and good practice
- [Volume 2](#) includes case-studies from around the world, including 19 case-studies of Australian day centres and residential care facilities.

6.1 Related TAPIB research papers

[RES 296 Home modifications and behaviours of concern](#) contains discussion of the principles of behaviour management for people with dementia.

[RES 268 Dementia supports.docx](#) contains general discussion of dementia, its various subtypes, symptoms and management strategies.

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Staffing strategies in positive behaviour support

The content of this document is OFFICIAL.

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The TAPIB Research team take care to ensure the research presented is accurate at the time of writing. Due to the nature of our work, we are not able to ensure that all relevant research has been considered in the development of this document or that information remains accurate after publishing.

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2. Summary

This paper describes the tag-in/tag-out support practice as an intervention to address behaviours of concern. This is a known practice among Australian behaviour support practitioners. No research was found that describes this practice specifically and so we have gathered evidence that describes more general or related behaviour support practices.

Tag-in/tag-out may be a kind of reactive strategy to address behaviours of concern, specifically a non-aversive de-escalation technique. Non-aversive reactive strategies are preferred to aversive strategies such as punishment or restrictive practice due to a combination of ethical and evidentiary concerns. Proactive strategies aimed at preventing behaviours of concern before they start are preferred to reactive strategies due to both evidentiary and ethical considerations.

Successful implementation of tag-in/tag-out requires a certain level and quality of support staffing. Organisational changes such as improved training of staff, maintaining consistency of support and providing a sufficient level of support are considered part of a best practice approach to positive behaviour support. However, the evidence supporting these strategies is ambiguous due to the necessarily individualised nature of positive behaviour support practices.

3. Tag-in/Tag-out support practice

Behaviour support practitioners may recommend a tag-in/tag-out support practice as a component of a participant's behaviour support plan. Tag-in/tag-out is planned sequential replacement of supports during or immediately before an escalation or potential incident. This practice is recommended by Australian behaviour support practitioners in the context of NDIS supports. How this practice is implemented may vary based on an individual's needs and preferences as outlined in their behaviour support plan. Generally, a support worker directly supporting a person identifies an escalation in the person's behaviours and that support worker then 'tags out' while a stand-by support worker 'tags in'. The goal of this practice may be a direct intervention to de-escalate the person's behaviour, such as redirecting them by changing their support context. It may also aim to address the support context itself by:

- substituting a support worker with a fresh perspective
- promoting staff safety
- reducing burnout
- maintaining a consistent support.

While the Agency is aware of this practice being recommended in NDIS funded behaviour support plans, we were unable to find any publicly available sources describing the practice. However, evidence exists for related and more general strategies such as non-aversive de-escalation techniques, changes to staffing levels and ratios, and other organisational or systemic interventions aimed at preventing or managing behaviours of concern.

Replacing support staff during an escalation may serve as part of a multi-component non-aversive de-escalation technique. Depending on the circumstances, it may be a proactive de-escalation technique or a planned reactive strategy (DHHS, 2018; NICE, 2015). Refer to section [5. Non-aversive de-escalation techniques](#) for further information.

Replacing support staff during an escalation may also form part of a broader environmental or foundational intervention aimed at organisational or systemic factors that impact behaviours of concern (Fisher & Kelly, 2025; Fisher et al, 2025). Staffing-related themes discussed in the behaviour support literature include:

- staffing levels
- ratios of support
- training
- quality of support
- consistency of support
- support staff wellbeing and risk of burnout.

These themes are explored more in section [6. Systemic or environmental approaches in positive behaviours support](#).

4. Previous TAPIB research

Previous TAPIB research paper [RES 217 Ratios of Support](#) discusses themes around staffing levels and staff management strategies used to address behaviours of concern. This 2021 review found very little evidence relating to the efficacy of higher staff ratios on managing behaviours of concern.

Other TAPIB research papers addressing themes related to managing behaviours of concern or the implementation and effectiveness of positive behaviour support, include:

- [RES 246 ABA and positive behaviour support](#)
- [RES 287 Sexual services and sexualised behaviours of concern](#)
- [RES 294 Effective management of auditory differences in people with autism](#)
- [RES 296 Home modifications and behaviours of concern](#)
- [RES 352 Home and living supports for people with dementia](#).

5. Non-aversive de-escalation techniques

Reactive strategies to manage behaviours of concern are practices implemented during an incident or escalation of behaviours. This has historically included aversive strategies such as such as punishments or restrictive practices. The effectiveness of aversive techniques is mixed and can often have the effect of exacerbating behaviours of concern. In addition,

evidence-based alternatives exist which do not risk violating a person's autonomy and human rights (NICE, 2015). Positive Behaviour Support combines a person-centred and rights-based approach with traditional behaviour analytic approaches and thereby de-emphasises aversive strategies in preference for evidence-based, non-aversive proactive and reactive strategies (Fisher & Kelly, 2025; Fisher et al, 2025; Nankervis & Vassos, 2023). According to Gore et al:

[while] physical interventions may be required in extreme situations to ensure people's safety, the use of and reliance on physical interventions is minimised in the context of PBS. Those working within a PBS framework are committed to using and developing non-aversive reactive strategies that reduce the escalation, distress and impact of behaviours that challenge within the context of a broader preventative approach (2022, pp.16-17).

Restrictive practices may still be employed as a last resort, though preference should be given to evidence-based proactive (systemic, organisational, or environmental) strategies and non-aversive reactive strategies aimed at de-escalation and ensuring safety of those affected by the situation (Fisher & Kelly, 2025; Fisher et al, 2025; Dowse, 2022). Non-aversive reactive strategies aimed at de-escalating behaviours include moving to a different environment, modifying environment to decrease arousal, removing triggers, strategic capitulation, verbal de-escalation techniques, distraction and diversion to preferred activities (Raising Children Network, 2025; Raising Children Network, 2024; Nankervis & Vassos, 2023; Gore et al, 2022; DHHS, 2018). De-escalation techniques can also be used as a pro-active strategy when staff observe early warning signs suggesting a developing escalation (Duxbury et al, 2024 DHHS, 2018; NICE, 2015).

6. Systemic and environmental approaches in positive behaviour support

One goal of positive behaviour support is to identify features of a person's environment and context that may promote or cause behaviours of concerns. This allows behaviours practitioners and support staff to implement antecedent interventions aimed at reducing the probability of challenging behaviours occurring. This is intended to reduce the need for planned or unplanned reactive strategies aimed at managing or responding to behaviours after they have occurred (Bruisma et al, 2025; Fisher & Kelly, 2025; Fisher et al, 2025; Jorgensen et al, 2023; Konstantinidou et al, 2023; NICE, 2015).

Australia's regulatory framework regarding restrictive practices and behaviours of concern emphasises that changes to a person's environment are a first-line strategy to prevent or manage behaviours of concern (NDIS Commission, 2025; Dowse, 2022). This may include consideration of the person's physical and sensory environment but also their routines, social environment, the quality and expertise of support staff, and the organisational policies and practices of the support provider (Fisher & Kelly, 2025; Fisher et al, 2025; Jorgensen et al, 2023; Konstantinidou et al, 2023; Dowse, 2022).

Consideration of the person's environment is a requirement for all behaviour support plans (NDIS Commission, 2025). This is required by legislation:

In developing and reviewing a behaviour support plan for a person with disability, the specialist behaviour support provider must take all reasonable steps to... make changes within the environment of the person with disability that may reduce or remove the need for the use of regulated restrictive practices (*NDIS Restrictive Practices and Behaviour Support Rules 2018*, s20.3).

In addition, a behaviour support practitioner must conduct a functional behaviour assessment (s20.5) which includes "an understanding of the relationship of events and circumstances that trigger and maintain the behaviour" (s5).

6.1 Staffing strategies to address behaviours of concern

Staffing related factors such as training, wellbeing, staffing levels, consistency of support, and support ratios can affect the occurrence of behaviours of concern and the use of restrictive practice (Dowse, 2022). The NDIS Quality and Safeguards Commission (NDIS Commission) practice guide *Organisational approaches to reducing restrictive practices* states:

Contextual and environmental factors may dictate the need for restrictive practices beyond the actual support needs of the individual. This may be more likely to occur in contexts where resources are constrained and where risk management may become the key driving factor in organisational decision making. For example, restrictive practices may relate to the built environment, resident compatibility, ignoring a person's wants and needs and staffing considerations including ratios, skills and shortages (Dowse, 2022, p.8).

A 2009 Victorian government report on the use of physical restraint in disability services summarises the ambivalent impact of staffing levels:

Higher staffing ratios have been suggested as a means of enabling early intervention and prevention of escalation. However, the availability of higher levels of staff have also been associated with a greater likelihood of staff using physical interventions, if for no other reason than they have the person power available to do so. Similarly, while lower staffing ratios make it practically more difficult to use restraint, lower staffing levels can also contribute to staff feeling anxious and consequently more likely to deploy restrictive practices earlier than they might otherwise do so had they the support (reassurance and security) of other staff close by who could offer assistance if required (McVilly, 2009, p.35).

More recently, McKeown et al report that in the context of care in mental health institutions, this ambivalence has not resolved with further study:

Staffing levels are implicated in adverse experiences of service users and staff within mental health ward settings, and they might contribute to levels of violence and

aggression and the application of restrictive practices, such as physical restraint but there is limited research evidence to support this (2019, p.1).

Qualitative studies investigating the views of professionals in a disability support context have found staff consistently report that insufficient levels of support staff are an important contributor to behaviours of concern (Duxbury et al, 2025; Leif et al, 2023; McKeown et al, 2019). Duxbury et al (2025) suggest that services need to provide a sufficient number of support staff with an appropriate mix of skills and attributes (age, gender, etc.) in order to minimise use of reactive strategies including restrictive practice. However, while staffing levels are recognised as a relevant factor in preventing and managing behaviours of concern, no specific recommendations regarding appropriate staffing levels were found. It is suggested that there need to be sufficient staff to employ those preventive strategies identified as foundational supports or within a person's behaviour support plan (Leif et al, 2023). For example, a person will require sufficient direct support to engage with activities that interest them, to perform necessary personal care activities, to redirect or engage their attention in cases of emotional dysregulation, to ensure the safety of themselves and the people around them etc.

Evidence suggests that higher staff to participant ratios are not sufficient to manage behaviours of concern. Other relevant factors include:

- matching staff to the person who are able to form a positive relationship (Leif et al, 2023; Dowse, 2022; Iffland et al, 2021)
- providing consistent support staff to ensure predictability and familiarity (Bruisma et al, 2025; Fisher & Kelly, 2025)
- training support staff in the principles of positive behaviour support and the details of the person's behaviour support plan (Bruisma et al, 2025; Duxbury et al, 2025).

7. References

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ASD Stocktake of Resources

Request: Provide a summary of all the resources and tools that TAT use to inform decisions about Autism Spectrum Disorder (ASD).

A summary of recent AAT cases and TAT advice requests (planning and access) and a data capture of all ASD related matters identifies the recurring key issues relating to ASD that TAT provide advice for.

1. Data capture 2017-2019 ASD related advice requests
2. HPRM ASD case search
3. AAT cases specific to ASD (planning and access)
4. Data capture 2014-2019 ASD related AAT cases

The resources have been split into the following categories:

5. NDIA resources (legislation, guidance, SOP's)
6. Individual information specific to person
7. TAT published advice
8. Yammer groups for NDIS staff relating to ASD
9. Key research resources
10. IRABINA related resources

Summary

The majority of referred to advices (1015 identified in the data table below) do not address autism beyond referencing that they are included (often as a co-presenting condition) among the participant's circumstances.

The vast majority of advices that the TAT research team were able to locate made no reference to any tools specific to Autism. In the majority, they refer to interpretation of legislation, or other internal instructions. Many are simply mandatory escalations to TAT regarding assistive technology for people whose complex circumstances include Autism.

The research team skimmed approximately 100/1015 identified ASD advices and consider the vast majority of advices reviewed not actually relevant to ASD. For example, these advices are about AT, communication, intellectual disability or other conditions and do not consider ASD specifically. The data simply reflects advices where ASD was one factor, not necessarily the primary issue being considered.

The most common request escalated related explicitly to Autism appears to be request for AT/communication devices for participants who are non-verbal. Most commonly an Apple tablet and associated accessories to support the communication application ProLoQuo2go. The only discussion regarding these requests appears to be the requirement for evidence of having trialled the devices, and the guidance to refer to base model devices rather than premium versions. The specific advice appears to be universal to communication devices for people with communication impairments and unrelated to Autism as a specific condition. The practice of trial before purchase, and use of base/'necessary' models rather than luxury models is effectively universal to assistive technology requests and is unrelated to Autism.

In cases where the question of access to the Scheme is raised, adequate evidence of diagnosis is the only discussion the TAT research team have been able to locate being referenced. The criteria to establish adequate evidence is not generally expanded upon within the advice, with the only specific example located indicating a brief discussion of not including diagnosis by a paediatrician. The advices the TAT research team have been able

to locate appear to predominantly refer to Autism as one of multiple conditions experienced by a participant being considered for access.

From the access escalations to TAT that the TAT research team have reviewed, it can be concluded that they reflect circumstances in which none of the participant's individual circumstances met access, and where the delegate has sought advice regarding the possibility that the sum capacity reduction of diverse circumstances may meet access.

Also, from informal conversations that the TAT research team has had with access delegates and advisors in the past that the guidelines for access to the scheme for participants with Autism are relatively clear and relate to the Autism CRC national guidelines and that a participant of the Scheme and require suitable evidence of diagnosis of ASD Level 2 or 3 under the criteria established in the DSM V.

The TAT research team have not yet located any access escalations to TAT where the evidence provided was clear and compliant with the CRC national guidelines. In cases where participants clearly have a disability level capacity reduction associated with Autism – the CRC guidelines are well understood by providers and closely match the established practices of providers in the sector. After analysis, the TAT research team have concluded that it would be relatively rare that a case containing ambiguous evidence would reach the TAT for advice.

1) DATA capture of ASD Advice Requests 2017 to 2019

Key data capture from 2017-2019 where advice request lists ASD as primary disability.

Theme	2017	2018	2019	Grand Total
Access - Initial Access			1	1
Access - Internal Review		3		3
Access - Other		2	1	3
Access - Revocation		6	2	8
Behavioural Supports / Psychosocial Disability	15	2		17
Capacity-Daily Activity	13	27	11	51
Capacity-Social, community & civic participation	3	5	1	9
Choice & control		2	1	3
Chronic Health Advice	4	15		19
Compensation	1			1
Complex AAT Reviews	3			3
Complex Assistive Technology	45	174	179	398
Complex Internal Reviews	9			9

Complex Physical Disability / Therapies	6			6
Consumables	1	3	6	10
Core-Daily activity	35	108	40	183
Core-Social, community & civic participation	1	9	3	13
Early Childhood	8			8
Employment	1	2		3
Functional Impact of Impairment	1			1
General R&N Advice	43			43
Health & Wellbeing		1		1
Home Modifications	32	39		71
Home Modifications-Complex		26	27	53
Home Modifications-SDA		26		26
Operational Policy Guidance	4	9	6	19
Other	1	1		2
Prosthetic & Orthotics	9	2	5	16
Relationships	3	2	2	7
Social, community & civic			1	1
Support Coordination	3			3
Transport	2	8	4	14
Vehicle Modifications	4	2	4	10
Grand Total	247	474	294	1015

	2017	2018	2019	Total
Autism	245	462	294	1001
Autism (secondary)	2	12		14
Total	247	474	294	1015

2) HPRM ASD case search

These 1000+ advices can be found through searching the TAT teams HPRM using the below search strings:

Title / Subject	Search String
AAT Actuary Report Autism Therapy 20180621	NED18/145609
Advices – Core Support	ADV + ASD + ADL
Advices – Restrictive Practices (behaviour support, ABA, other therapy interventions)	ADV + ASD + THER
Advices – Assistive Technology	ADV + ASD + AT
Advices – Home Modification	ADV + ASD + HMOD

Specific HPRM advices that contain research docs

As mentioned above many of the 1015 TAT ASD advices identified as relating to ASD are not primarily about ASD. However during the skim review of 100 these two advices were isolated because they contain references to specific ASD resources.

HPRM NED19/137843 - Adv 2018/7294 relates to an assistance animal for a participant with a service animal and provides some context and expansion around the decision that may be relevant to this review of resources.

It indicates that in March 2016 NDIA commissioned La Trobe University to review the evidence of effectiveness of assistance animals – see NDIA LTU Advice on Assistance dogs



ADV 2018 7294 NDIA LTU advice on
CORE assistance ani assistance dogs.pdf



HPRM – NED19/100608 - Adv 2018 / 7867 regarding ABA therapy for a 6 year old includes substantial research and several external links and resources.



ADV 2018 7867
THER 20 hours per w

3) AAT Cases Specific to ASD

The historical/active cases have been split into access and planning.

Access:

ASD matters we receive through the AAT for access:

- The TAT AAT access team have received a number (not sure exactly how many as there are a few advisors who work on the access cases) of applications from adults (over 40 and even in their 60's) who have had a fairly recent diagnosis of ASD Level 1. They are requesting access for assistance with social skills noting that they lack the ability to build and maintain relationships.
- The main argument used is that they have obviously always had ASD as this is not something you suddenly 'get'.
 - o All the Applicants have finished their education, worked, married and had children prior to their diagnosis.
 - o They have been able to manage their life, albeit some have had some difficulty with social interaction and communication, however, they do not meet the criteria of their impairment resulting in substantially reduced functional capacity.
- Many believe that simply having the diagnosis should grant them access to the Scheme.
- The TAT AAT access team also have adults being diagnosed with ASD because they have children with the diagnosis and then they are referred for assessment.
- The team have engaged independent occupational therapists to undertake a full functional assessment of the Applicant in their home to determine what difficulties they experience in the domain areas of Mobility, Learning, Communication, Social Interaction, Self-Management and Self-Care (these are the domain areas considered for access to the Scheme). They need to have substantial impact in one or more of these areas to meet access.
- As yet, the team have not had any assessment that supports the Applicant meets the threshold of substantially reduced functional capacity.
- The difficulties the TAT AAT team experience is that many health and allied health professionals are familiar with the wording used for a person to be granted access to the Scheme, particularly for early intervention. The team have identified some health/allied health professionals who note that the person requires intensive speech or psychological therapy to improve their current function and this would alleviate future disability support needs. If the person is an adult and there is no evidence of any intervention being completed in the past they may meet EI criteria for access. We have granted access in these instances.
- Another issue the TAT AAT team have identified is that many adults are not diagnosed using the DSM-V but rather the ADOS-2.
 - o While the ADOS-2 is regarded by those who use it as 'gold standard', the severity level does not align with the DSM-V.
 - o As List A notes a person with Level 2 or Level 3 ASD does not need to provide any evidence around the impact of their condition and would meet the access criteria, it is difficult to align an ASD diagnosis when no level of severity is provided if the diagnosis was made using the ADOS-2.

Planning:

ASD matters we receive through the AAT for planning have the following key themes:

- Families of pre-schoolers and early school years age children with ASD requesting high level of therapy supports to pursue ABA.

- In many therapy has been delivered at high levels (greater than 20 hrs/week) for several years.
- These parents have often done their own research (or at times advised by the paediatrician) to determine that ABA is the 'gold' standard treatment.
- Early experiences of limited/no success with conventional therapy which often looks like individual SP perhaps with OT.
- Greatest number of requests for high levels of ABA proceeding to AAT coming from NSW.
- While centre based ABA therapy approaches exist in all states, in Victoria there are a number seeking funding for a 27hr/week program run by Autism Partnership. There may be an argument for this support for those children not able to manage in an Early Learning & Care (EL & C), but in most other situations the relative responsibilities of NDIS in terms of support and parent responsibility of funding EL & C opportunities is not clear.
- Overall limited evidence ECEI best practice in intervention with children and families with ASD.
 - Claims by ABA providers of following ECIA best practice in Early Childhood intervention National Guidelines when clearly they do not.
 - Provider reports often fuel parent expectations that more therapy is better and will overtime eliminate the delay between their children and others (no matter the severity of the ASD presentation)
- Parents and ABA providers using the reference to the recommended 20 hrs/week of early intervention referred to in Roberts and Williams 2016 to mean ABA therapy
- Parents not seeing/valuing the intervention they provide (often reinforced by providers saying parents needed to be parents) & providers breeding dependence by stressing skills need to be mastered with therapists before being 'generalised' by parents into other areas.

The following AAT cases relating to ASD planning matters that resulted in published findings have been identified:

Title	Date	Brief detail of decision	Link
TKCW and National Disability Insurance Agency [2014] AATA 501 (23 July 2014)	23-Jul-14	Intervention requirements - reasonable and necessary supports	http://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/cth/AATA/2014/501.html?context=1;query= National Disability Insurance Agency;mask_path=au/cases/cth/AATA
ZNDV and National Disability Insurance Agency [2014] AATA 921 (25 November 2014)	25-Nov-14	Support not reasonable, relative to likely benefits ; To incorporate the terms of a further plan	http://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/cth/AATA/2014/921.html?context=1;query= National Disability Insurance Agency;mask_path=au/cases/cth/AATA

McGarrigle and National Disability Insurance Agency [2016] AATA 498 (15 July 2016)	15-Jul-16	Not reasonable and necessary supports ; transport costs; taxis	http://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/cth/AATA/2016/498.html?context=1;query= National Disability Insurance Agency;mask_path=au/cases/cth/AATA
LJJY and National Disability Insurance Agency [2018] AATA 3506 (18 September 2018)	18-Sep-18	Not satisfied that it is a reasonable and necessary support; subsection 34(1)(c) and subsection 34(1)(d)	http://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/cth/AATA/2018/3506.html?context=1;query= National Disability Insurance Agency;mask_path=au/cases/cth/AATA

4) Data capture for AAT matters relating to participants with ASD (Asperger's and Autism)

There have been 334 AAT matters relating to participants with an ASD (Asperger's and Autism) during the 2014-2019 period. The increased number in AAT cases in 2018 likely reflects the timing of state and territory full scheme transitions, particularly SA.

Split by Year;

Year Received	AAT Matters Relating to ASDs
2014	5
2015	10
2016	19
2017	80
2018	208
2019	12
Total	334

Split by Age;

Age Range	AAT Matters Relating to ASDs
0-6	58
7-18	185
Adults	87
No Age Recorded	4
Total	334

Relating Exclusively to ASD (no other disability listed)

Disability	AAT Matters Relating to ASDs
ASD and other disability	56
ASD only	278
Total	334

Row Labels	AAT Matters Relating to ASDs
ASD and other disability	17%
ASD only	83%
Total	100%

5) NDIA resources (legislation, guidance, SOP's)

There are key pieces of legislation, practice guidance, operational guidance and SOP's that provide the overarching framework for all TAT access and planning advice.

NDIA resource	Link
Legislation	The National Disability Insurance Scheme Act 2013 (the NDIS Act) The National Disability Insurance Scheme (Supports for Participants) Rules 2013 (the Supports for Participants Rules) NDIS Restrictive Practice and Behavioural Support Rules 2018 NDIS (Supports for Participants) Rules 2013
Practice Guide	Practice Guide – Intensive Super Intensive Participants.
Standard Operating Procedures	SOP Behaviour Intervention Supports
Scheme Actuary	Autism Therapy Support – Potential Impact on Scheme Financial Sustainability (June 2018)

6) Individual information specific to person

When TAT provide advice on access or planning decisions (including AAT cases), participant specific information is always considered. This is because advice is always given on a case by case basis. For example, clinical assessments, expert opinions, letters from medical or other health professionals will be considered.

7) TAT Published Advice

TAT publishes a list of de-identified, general advices on the TAT Digest page [NDIS Intranet](#). A recent tracking exercise has identified that the TAT Digest page is widely utilised across the agency as a key resource.

There are eight TAT Published Digest relating to ASD:

Request title: Funding of out of school hours care, 6 hours access to community on Saturday, 576 hours short term accommodation for a 10 year old.	https://intranet.ndiastaff.ndia.gov.au/service-delivery/Technical-Advisory-Team/Documents/COPA%20ADL%20THER%20funding%20of%20access%20to%20community%20and%20short%20term%20accommodation%20for%
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	2010%20year%20old%20with%20autism%2020180514%20KRN451.pdf
Request title: Review of high cost plans for twin brothers submitted for approval and determination of reasonable and necessary supports.	https://intranet.ndiastaff.ndia.gov.au/service-delivery/Technical-Advisory-Team/layouts/15/WopiFrame.aspx?sourcedoc=/service-delivery/Technical-Advisory-Team/Documents/ADV%202016%201556%20%202016%201557%20BEH%20THER%20Review%20of%20high%20cost%20plan%20for%20twins%20with%20ASD%2020160227%20SH0031.pdf&action=default
Request title: Assistance Animal for a child with Autism and Epilepsy	https://intranet.ndiastaff.ndia.gov.au/service-delivery/Technical-Advisory-Team/Documents/THER%20Empowerment%20Assistance%20Dog%20for%2018%20year%20old%20man%20with%20Autism%20SAP%20592.pdf
Request title: Request for NDIS to fund Applied Behavioural Analysis (ABA) link therapy and Music Therapy for 10 year old child with Autism Spectrum Disorder (ASD).	https://intranet.ndiastaff.ndia.gov.au/service-delivery/Technical-Advisory-Team/Documents/ADV%202016%201112%20THER%20Requested%20supports%20fund%20Behaviour%20Analysis%20(ABA)%2010%20year%20old%20child%20with%20Autism%20(ASD)%2020170406%20KM0032.pdf?
Request title: AT - Freedom jogger pusher fitted with Pelvic strap, Rain canopy and Highback Kit.	https://intranet.ndiastaff.ndia.gov.au/service-delivery/Technical-Advisory-Team/Documents/AT%20Freedom%20stroller%20with%20accessories%20for%2010%20year%20old%20child%20with%20ASD%20and%20a%20Chromosomal%20disorder%20-%20201709%20MF0018.pdf
Request title: Weighted Blanket for participant with Autism	https://intranet.ndiastaff.ndia.gov.au/service-delivery/Technical-Advisory-Team/Documents/AT%20Weighted%20Blanket%20Autism%2020161107%20BSK479.pdf
Request title: Swimming and flexible respite/recreation/holiday care for a 6 year old with Autism.	https://intranet.ndiastaff.ndia.gov.au/service-delivery/Technical-Advisory-Team/Documents/ADV%202016%202529%20swimming%20and%20flexible%20respite-recreation-holiday%20care%20for%20a%206%20year%20old%20with%20Autism.pdf?

8) Yammer groups for NDIS staff relating to ASD

There are two Yammer groups for NDIS staff discussion that some TAT advisors use:

- [Autism Spectrum Disorders](#)
- [Understanding the Autism Spectrum by Dr Bennett, PHD](#)

9) Key research resources

The below resources have been frequently made reference to in advices or TAT advisors have indicated that these are key resources they make reference to.

- [Autism CRC](#) – Source of the Autism CRC National Guidelines
 - The TAT Research team has been advised that the CRC is frequently used by advisors for assessment/diagnosis for informal advices.
- 

Autism CRC
National Guideline (
- [Raising Children – Autism](#) – An Australian parenting resource with an extensive series of Autism resources.
 - The TAT Research team has been advised that the raising children website is frequently used by advisors for best practice information.
- [Neurofeedback in autism spectrum disorder](#)
- [Early Intervention for Children with Autism Spectrum Disorders: 'Guidelines for Good Practice' 2012 \(DHS Australia\)](#)
- [Richard Simpson, Evidence-Based Practices and Students With Autism Spectrum Disorders](#)
- [Aspect Australia](#) – Australia's largest service provider
- [Autism Advisory Board](#) – The national Autism peak body
- [Amaze Resources](#) – The Victorian Autism Peak Body's resources page
- [Asia Pacific Autism Conference 2021](#) – A major conference scheduled for late 2021 that will likely be relevant in future.

10) IRABINA related resources

Information stated by IRABINA advises that *"IRABINA is Australia's only Autism specific service provider for children and young people with the only severe behaviour program in the Asia Pacific Region. We will not turn anybody away and provide every Autism specific service. We can deliver services in your home, school, kindergarten or at one of our three sites across Melbourne"*.

IRABINA is a reputable provider of services for high end behaviour support / complex behaviour support for children with ASD.

Over the past year TAT have worked with Steph Gunn and IRABINA regarding best practice and costings for two specific participants requiring CSIR (TAT can provide names if required). These two participant cases demonstrate specific information about the IRABINA program and how TAT worked out funding advice.

One of the participant's being discussed through CSIR with IRABINA was receiving supports through the 'server behaviours program'. A summary of this IRABINA program can be found in this attachment.



IRABINA severe
behaviours program

Deb Clark – TAT Branch Manager is now the key Agency contact for IRABINA.

There are general resources that can be found on the [IRABINA website](#).

IRABINA frequently provide additional supporting documents and clinical reports to enable NDIA reasonable and necessary decision making to be made.

The following are the advices directly related to IRABINA as the provider of high cost behavioural supports for children with ASD:

- Electronic Document NED18/197780
 - o ADV 20182325 IR ADL THER HMOD request for home extension home modifications person to person supports and communication device child with autism behaviours of concern 20181017 KRN451
 - o 15/10/2018 at 1:16 PM
- Electronic Document NED19/67206
 - o ADV 20181281 ADL THER Core Supports and High Cost Severe Behaviour plan 2018.08.31 KRN451
 - o 28/09/2018 at 2:23 PM
- Electronic Document NED18/223024
 - o ADV 20182530 ADL THER One month review of high cost three month ABA intervention for a 12 year old with autism and severe intellectual disability 20181411 KRN451
 - o 13/11/2018 at 3:11 PM