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| Treatment plan guide |
| Compulsory treatment – Senior Practitioner |
| OFFICIAL |

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# Preamble

An Authorised Program Officer, appointed by the disability service provider or the NDIS registered provider and approved by the Victorian Senior Practitioner, is responsible for the development and submission of a treatment plan for a person with an intellectual disability, as specified under sections 153, 167, 180(6) or 191 of the *Disability Act 2006*.

The treatment plan should be developed in collaboration with:

* the person subject to compulsory treatment
* the clinician providing oversight of the plan
* the author of the assessment of risk
* the stakeholders responsible for direct support and supervision.

It is recommended that the clinician providing oversight of the treatment plan and contributing to its development be an NDIS registered behaviour support practitioner to facilitate reporting of compulsory treatment to the NDIS Quality and Safeguards Commission.

# Section A

| Item | Example or guidance |
| --- | --- |
| Name of person, date of birth | Mr Joe Average  03/05/1965 |
| CRIS number | 1346113 |
| Start date | 01/01/2021  **Note**: This date should be the date the plan is finalised and approved by the APO. |
| End date | 30/12/2021  **Note**: This date cannot exceed 12 months and can be later changed by the Senior Practitioner |
| Disability service provider or Registered NDIS provider | X – IT Test |
| Order type | Supervised treatment order, residential treatment facility orders at the Intensive Residential Treatment Program IRTP and the Long Term Residential Treatment Placement (LTRP) |
| Service setting address  Where the person lives for the duration of this plan - not the address of the disability service provider or registered NDIS provider | Smith Congregate Care – Fitzroy 145 Smith Street, Fitzroy  Section 191(1)(b): An Authorised Program Officer for a disability service provider may apply to VCAT for a supervised treatment order to be made for a person ‘who is receiving residential services’  Section 191(1A)(c): An Authorised Program Officer for a registered NDIS provider may apply to VCAT for a supervised treatment order to be made for a person ‘who is an SDA resident living in an SDA enrolled dwelling provided under an SDA residency agreement’  Section 153 (1) Within 28 days after a person with a disability is admitted to a residential treatment facility, the Authorised Program Officer must prepare a treatment plan. |
| Application to VCAT | 01/12/2021  **Note**: This is the date the application to VCAT was submitted |
| Senior practitioner certificate end date | **Note**: This date is to be added by the Victorian Senior Practitioner |
| VCAT order date | **Note**: This date will be added by VCAT upon making the order |
| Author | The person primarily responsible for writing (or coordinating the development of) the plan. |
| Author’s contact | 123 |
| Clinician providing oversight | First Name Last Name  This is the person who is responsible for overseeing the clinical components of this plan. |
| Clinician’s contact | 123 |
| Sources of information | This should include sources of information that have been used to inform the development of this plan. All documents and reports used to inform the development of the treatment plan should be attached to the treatment plan and must include a risk assessment. A baseline quality of life assessment should also be completed.  Some sources of information may be older (such as eligibility assessments); however, please note that risk assessments must be current and, therefore, should not exceed 12-month reviews.  Even if you have previously named sources of information in previous plans, if they have been used to inform this plan, name them again and be attached to RIDS for each new plan. |
| APO |  |
| APO’s contact |  |
| Endorsing plan |  |
| Endorsing plan date | This will be added automatically |
| Senior Practitioner approval | Section 191(1)(c): An Authorised Program Officer for a disability service provider may apply to VCAT for a supervised treatment order to be made for a person – ‘…a treatment plan approved by the Senior Practitioner’  Section 191(1A)(d): An Authorised Program Officer for a registered NDIS provider may apply to VCAT for a supervised treatment order to be made for a person – ‘…a treatment plan and attached NDIS behaviour support plan have been approved by the Senior Practitioner’  Section 153 (1) Within 28 days after a person with a disability is admitted to a residential treatment facility, the Authorised Program Officer must prepare a treatment plan.  **Note**: The Victorian Senior Practitioner behaviour support plan is included in the treatment plan template and the restrictive practices used are authorised by the Victorian Senior Practitioner through the treatment plan certificate.  The [**About the person**](#_About_the_person), [**Behaviours of concern**](#_Behaviours_of_concern), and the [**Restrictive practices for behaviours of concern**](#_Restrictive_practices_for_1) sections **must** be completed. |
| Approval date |  |

## About the person

### History

Think about the person’s history and the impact this has had on their behaviours.

Then think about if there are any of these factors which may impact on the person’s engagement with treatment and this treatment plan?

**Note**: This section must be completed to meet the requirements of a Behaviour Support Plan (BSP).

#### What to include

* Indicate the person’s level of intellectual disability. Name the supporting documentation referring to the person’s formal diagnosis.
* Adaptive behaviour assessment – referring to the results of a standardised measure, clarify the level of support the person requires and refer to where planned interventions/support strategies will target any deficits identified.
* Is there evidence of the client having a comorbid disorder from childhood (such as autism, ADHD, oppositional defiant disorder, conduct disorder, attachment disorder or issues, ABI)
* Is there any recorded evidence of the person experiencing abuse or neglect, such as sexual, emotional or physical abuse, or neglect and emotional deprivation?
* Are there any significant life events that would impact on the person’s behaviour or support needs?
* What were the person’s previous living arrangements and involvement across services?
* Who does the person currently live with?
* Does the person have a history of engaging in behaviours of concern? If yes, complete the [**Behaviour of concerns**](#_Behaviours_of_concern) section, including the functions of the behaviour.
* Has the person had previous involvement with the justice system?
* What intervention or strategies have previously been tried?
* What was the effect of these interventions?

### Health

This section relates to both the person’s physical, neurological and mental health.

Refer to the person’s mental health plan or intensive case review, as well as health plans, for a reference to **all** of the person’s health needs and recommendations regarding treatment and support.

**Note**: This section must be completed to meet the requirements of a BSP.

#### What to include

On RIDS you will need to enter and select from the following list, entitled 'Is there evidence of the person having a co morbid psychiatric disorder?'

##### Evidence of the person having a co-morbid psychiatric disorder

* Is the person currently receiving treatment for this mental illness? Yes or no.
* Does the person have a mental health plan? Yes or no. If **yes**, please attach mental health plan.
* Does the person have a syndrome, genetic (such as Fragile X) or other (such as ABI)?
* Is there evidence of the person having a comorbid psychiatric disorder present in adulthood (such as schizophrenia, paranoid disorder, bipolar disorder, depression, obsessive compulsive disorder, severe anxiety disorder, personality disorder)? Please attach evidence.
* Does the client have a chronic physical disorder (such as epilepsy, diabetes or neurological problem)?

If the person does have a mental health diagnosis, include within this section what the symptoms associated with this health need look like for the person.

You should also consider if there are any implications or side effects of the person’s medication on their physical health. If so, then you need to add how the impact on their physical health will be treated and monitored.

**Note:** Include all medications, doses, and rationale for medication that are not considered a restrictive practice. The medication considered to be a chemical restraint should be reported under [**Section C: Restrictive practices**](#_Section_C:_Restrictive), listed as a chemical restraint. Within that section you will need to confirm the medication type, dose and rationale for the medication (that is, what is the benefit of the medication).

### Communication

Has a communication assessment been completed?

Is this something that should be added into the treatment section as being required? Communication can be a significant barrier to treatment – this could be critical information when designing strategies for both the client and staff

**Note**: This section must be completed to meet the requirements of a BSP.

#### What to include

**Note**: Please attach communication assessment if it has been completed, and summarise it in this section.

Think about how the person’s communication style affects the way treatment should be delivered or their support:

* Does the person speak English as their primary language? If not, what is their preferred language for both verbal and written communication?
* Does the person communicate verbally?
* Does the person communicate via non-verbal methods (such as Auslan)?
* Does the person use any communication aides (such as personal communication dictionary, electronic communication device, interpreter pictographs like COMPIC, real objects or object symbols)?
* Does the person have any strengths or deficits in receptive language?
* Does the person have any strengths or deficits in expressive language?
* Can the person read? Please specify level of literacy if known.
* Does the person require documents to be presented to them in an alternate form (such as Braille, Easy English, plain English, pictures, with verbal explanation, verbal repetition or social stories)?

### Likes and dislikes

The environment the person functions within can be either a risk or protective for them. Knowing their likes and dislikes can facilitate more proactive strategies to be developed to manage their risk.

**Note**: This section must be completed to meet the requirements of a BSP.

#### What to include

* What does the person like? Include interaction styles, level and types of activities, choice and so on.
* What does the person dislike? Include interaction styles, level and types of activities and so on.
* What is important that they have or don’t have in their life?
* Can access to the person’s likes or wants be integrated into this plan?

### Sensory needs

Has a sensory assessment been completed? If not, is this required to be completed during the life of this plan?

Think about how the person’s sensory needs affect their engagement with their environment and treatment. This information can be a potential barrier to their progress in treatment and guide the development of appropriate strategies.

**Note**: This section must be completed to meet the requirements of a BSP.

#### What to include

**Note**: Please attach sensory assessment if it has been completed, and summarise it in this section (if applicable).

Does the person:

* have any visual impairment?
* have any hearing impairment?
* seek out sensory experience?
* avoid any sensory experience?
* engage in behaviours of concern that appear to be related to their sensory needs?

### Personal goals

The person engaging in the behaviour change needs to be motivated (focus on intrinsic needs, goal setting and maximise protective factors that are meaningful to the person).

Remember this is the person’s treatment plan – by prioritising their goals within this plan, it is likely the person will be more motivated to comply and engage more effectively in treatment.

#### What to include

During the life of an order, the person’s progress towards goals should be regularly reviewed.

* What does the person want to achieve in their life, in the short and long term? What do they think is important enough to work towards achieving?
* What are the steps needed to help the person achieve this goal Think about the skills required to achieve this goal and link this to the person’s treatment goals and interventions.
* What support can be put in place to achieve small successes towards this goal, so that the person’s motivation can be maintained and that their goals remain a priority within this plan?

**Note**: Think about using a standardised **quality of life measure** to evaluate the person’s sense of quality of life and wellbeing. This information can inform where to target their goals and, if reviewed during the life of the plan, can be a good outcome measure. Add this to [**Section B: Treatment process**](#_Section_B:_Treatment).

### Other, employment, relationships

Think about how the person’s previous relationships and /or employment has related to their offending.

Then think about how the person’s access to employment, vocational work, recreational programs or relationships are linked to their goals and what skills are required to achieve these goals.

**Note**: This section must be completed to meet the requirements of a BSP.

#### What to include

Where did the person previously live when in the community? Were they independent, did they live in supported accommodation, have they had periods of homelessness?

Indicate who is in the person’s family and the level of contact and type of support provided by the family.

Does the person have, or have they had, any intimate relationships apart from family?

Indicate how the person spent their time when in the community – are or were they employed or engaged in a day program (choose one of the following options)?

* Open employment
* Supported employment
* Voluntary work
* Other day care or day program
* Attending college or educational facility
* No formal daytime activity

### Case formulation

**Both the case formulation and ‘About the person’ sections must be completed for the treatment plan.**

Both sections must be completed in full, as the complexity and diversity of issues involved in forensic risk assessment and management suggest a role for formulation as an essential coordinating and explaining process.

#### What to include

Formulation is applicable to all people with behaviours of concern, regardless of cognitive functioning or disability. In contrast to a diagnosis, a formulation ‘tells the person’s story’. The formulation must be a collaborative effort between the clinician, the person and staff and carers from the relevant settings.

Formulation is a hypothesis about the nature of behaviours, their causal (or functional) relationship between variables and events and the behaviour. It is an individualised theory that seeks to describe and explain how the client's experiences and beliefs (underlying mechanisms) shape their thoughts, mood and behaviour.

It provides a summary of the client's presentation, gained from a thorough assessment, which draws together important features to facilitate the development of a treatment plan which includes what the person is ‘striving for’ (that is, the person’s goals and how they can benefit from engaging in treatment).

When undertaking a formulation, note that it is rare for a person’s behaviour to be explained by a single cause. The behaviour of concern may have originally had a single function but is likely to have escalated to numerous biopsychosocial functions requiring multicomponent intervention.

Features of a formulation (see Figure 1) are based on a functional assessment and should include:

* the identified behaviour – summary of the main problem and any other presenting problems (might include a problem list)
* vulnerability factors – how these problems developed (human needs). What are the factors that increase a client's vulnerability or predispose them for offending or offending-like behaviour?
* setting events – temporally distant and idiosyncratic antecedent events that relate to the problem behaviour
* triggers or precipitants – factors that are immediate triggers for engaging in the offending or offending-like behaviour, such as feelings of anger or depression, being exposed to target group, intoxication (acute dynamic risk factors).
* maintaining factors – factors that maintain engaging in or reinforce the offending or offending-like behaviour, such as having a circle of friends who engage in similar behaviour, reasons for engaging in these behaviours (beliefs), previous failed attempts to stop or not contemplating change (long term dynamic risk factors).
* protective factors – these may be **internal** (specific abilities, likes or interests, strengths, motivations such as fearing the consequences to themself of further offending, expressing some level of remorse and a willingness to engage in treatment) or **external** (supportive relationships with carers or staff) and may act as buffers between the existing vulnerabilities of the person and behaviours.

The case formulation should be constantly revisited and revised throughout the intervention to monitor the client's progress and evaluate the effectiveness of the intervention.

The treatment plan developed should be based on the information gained from the assessment and the formulation, be individualised and emphasise the relevant aspects of the intervention as appropriate for the person's:

* readiness to change
* level of motivation
* level of commitment
* skills
* goals for treatment.

Figure : Formulation template

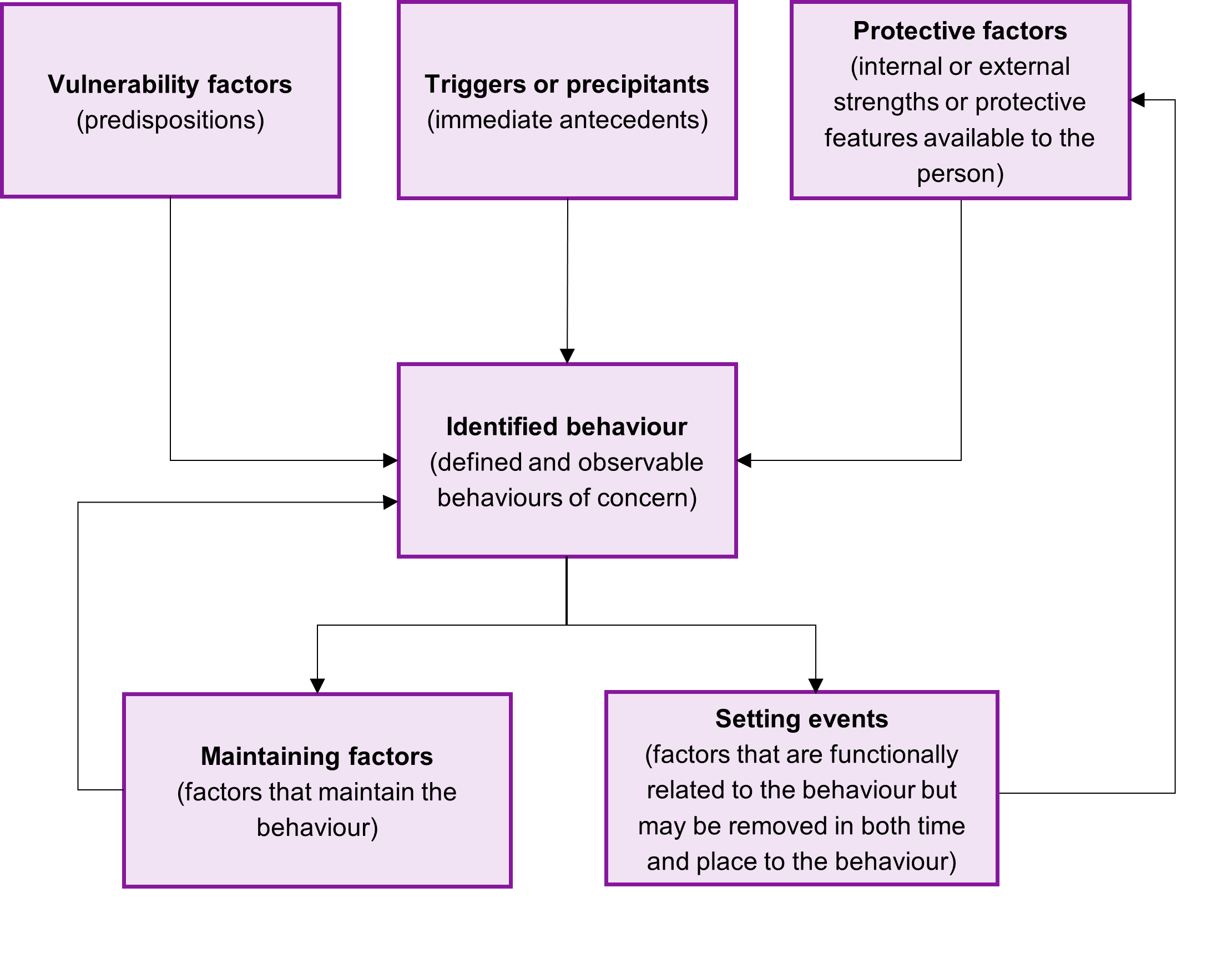


Figure note

Emerson, E, Cummings, R, Barrett, S, Hughes, H, McCool, C and Toogood, A 1988, ‘Challenging behaviour and community services: Who are the people who challenge services?’, Mental Handicap, 16, 16–19.

DHHS, Positive practice framework, January 2018, section 14.2.

##### Image description – formulation template

First three elements:

* Vulnerability factors (predispositions)
* Triggers or precipitants (immediate antecedents)
* Protective factors (internal or external strengths or protective features available to the person).

Next step: go to ‘Identified behaviour’

Identified behaviour (defined and observable behaviours of concern). Next step: go to ‘Maintaining factors’ or ‘Setting events.

Maintaining factors (factors that maintain the behaviour). Next step: go to ‘Identified behaviour’.

Setting events (factors that are functionally related to the behaviour but may be removed in both time and place to the behaviour). Next step: go to ‘Triggers or precipitants’.

## Offending behaviours

**Note**: This section contains information about ‘offending behaviour’ and the next section contains information about ‘behaviours of concern’.

**Offending behaviour** is the behaviour which has resulted in the need for the person to be detained (and the order applied for). It presents as a significant risk of serious harm to another person and often, but not always, results in involvement with the criminal justice system.

**Behaviours of concern** are behaviours which present as resulting in physical harm to the person or another person or property damage where there is a risk of physical harm to the person or another person. There is **no need** to detain a person for these behaviours, although there are often restrictive practices associated with them. Without an order and a treatment plan these would likely be managed through a behaviour support plan.

### Offending (type) behaviour

Select one or more of the following:

* sexual violence (Chose ‘Adult’, ‘Child’ or ‘Other’ from the drop-down list – ‘Other’ requires free text entry)

**Or:**

* non-sexual violence
* fire lighting or arson
* other

#### What to include

Define the behaviour – what category of offending (type) behaviour are you trying to describe?

### Other behaviour

#### What to include

Free text field for offending behaviour that does not fit into any of the ‘Offending (type) behaviour’ categories.

This is where the description of the behaviours, including previous charges or incidents can be discussed in more detail.

### Has the person been convicted for this behaviour?

#### What to include

Yes or no.

### Has the person been incarcerated for this offence?

#### What to include

Yes or no.

### Behaviour description

The content to be included within this entire section should be taken from a current risk assessment.

This assessment should be reviewed at least on a six to 12-month basis to be considered ‘current’.

#### What to include

Describe the behaviour in a way that allows all people supporting the person to understand what the behaviour looks like and measure its occurrence.

This behaviour should be the behaviour which presents as a significant risk of serious harm to another person. It can include behaviour which may or may not result in formal contact with the criminal justice system; however, this needs to be the primary behaviour which led to the application for a compulsory treatment order.

**Note**: The person’s level of risk of reoffending or causing harm towards others should be reported here. This information relates to section 191(6)(a) and (b) of the Disability Act, which state the person’s level of risk towards others should be considered ‘significant’ and there should be a known pattern of this behaviour.

The person’s level of risk should be directly linked to the intensity of the treatment provided and the level of supervision as the least restrictive under the circumstances.

### Offending pathway or description

#### What to include

This information may already be discussed in the person’s case formulation section. This information should include the precipitating factors which influenced the person’s offending or incident which posed the significant risk of harm towards others.

For example, were there any environmental or client factors which influenced their motivation or opportunity to offend? This information can be found within a functional behavioural assessment as well, to highlight what may have been reinforcing this behaviour or the skill deficits which contributed to the person’s behavioural patterns.

**Note**: This information links to critical risk factors identified within the risk assessment and should be considered when confirming the person’s community access. For example, what environments are considered high risk and low risk situations and whether independent community access is appropriate at particular times.

### Protective factors

These factors should be prioritised, maintained and maximised during the life of this plan as a critical feature of the person’s risk management.

Protective factors may be:

* internal – specific abilities, likes or interests, strengths, motivations such as fearing the consequences to themself of further offending, expressing some level of remorse and a willingness to engage in treatment
* external – supportive relationships with carers or staff.

These factors may act as buffers between the existing vulnerabilities of the person and behaviours.

#### What to include

What strengths does the client have that will assist them to engage in treatment or manage their risk?

**Note**: This information is likely to be found in your current risk assessment. For example, the ARMILDILO risk assessment explicitly states protective factors for both the client and within the environment.

### Dynamic risk factors

These factors should be prioritised to be managed through the provision of intervention, relapse prevention strategies, skill development or supervision.

#### What to include

Dynamic risk factors are those which are potentially changeable and when reduced, are associated with a reduction in recidivism risk (repeating or returning to criminal behaviour). Dynamic risk factors can be further divided into ‘stable’ and ‘acute’ risk factors.

Stable risk factors are relatively enduring attributes associated with chronic recidivism risk. They change slowly over time. Stable dynamic risk factors (such as emotional coping ability or sexual deviance) need to be identified to be addressed in treatment.

Acute risk factors, also called ‘triggers’ or ‘triggering events’, are short-term states that can change quickly and signal the timing or give warning of the offending behaviour (such as not coping or being intoxicated). Acute dynamic risk factors determine what needs to be restricted or monitored in the environment or community.

## Behaviours of concern

**Note**: This section must be completed to meet the requirements of a BSP.

### Behaviour

Select one or more from the following:

* harm to self
* harm to others
* harm to self and others
* destruction of property and harm to self
* destruction of property and harm to others
* destruction of property and harm to self and harm to others

#### What to include

This section relates to any other behaviour (potentially offence-parallel behaviour) which is considered concerning and require intervention.

What category of behaviour are you trying to describe (harm to self, harm to others, property damage and so on)?

This is different from the offending (type) behaviour.

For example, the person may sexually offend against children (offending behaviour) but may also engage in self injurious behaviour (harm to self) or be physically assaultive towards others (harm to others) or damage property.

The term ‘behaviour of concern’ acknowledges the trepidation that disability service providers and allied health professionals have related to restrictions and responses imposed on people with an intellectual disability from a Convention on the Rights of Persons with Disabilities (CRPD) perspective and can be defined as:

‘behaviours that indicate a risk to the safety or wellbeing of the people who exhibit them or to others. Unless professionals intervene to prevent such behaviours, therefore, they are likely to affect communal, social or occupational quality of life of the people involved, and may lead to their rights being restricted.’

### Behaviour description

**Note**: This section **must** be completed as it forms part of the NDIS behaviour support plan within the treatment plan.

However, as this is a holistic plan, this section is valuable to look at all of the person’s behaviours and related skill deficits to ensure that that this plan addresses all of the person’s risks and needs.

#### What to include

Describe what the behaviour looks like, in specific and measurable terms.

It is important that everyone agrees on the description of what the behaviour looks like so that people can recognise the behaviour when it occurs, respond in a consistent manner and everyone is measuring the same thing.

Include:

* how often it occurs (frequency)
* how long it lasts (duration)
* what harm is caused (intensity)
* the last time the client used the behaviour
* how long the client has been using this behaviour if known.

**Note**: It is important that you include the frequency, intensity and duration of the behaviour so you can measure change over time. Refer to baseline evidence, where applicable, and how that information was gathered and summarised.

### Behaviour of concern – triggers and setting events

Select one or more of the following:

* activity
* communication
* people
* physical environment
* place
* routine
* time
* other

For every selection, a description is required under each heading

**Note**: This section must be completed to meet the requirements of a BSP.

#### What to include

Describe:

* what usually happens just before the behaviour of concern occurs that leads to the behaviour occurring (trigger)
* what happened before the trigger to make the behaviour more likely to occur (setting event).

Look for triggers and settings events you may have identified in the [About the person](#_About_the_person) or [Case formulation](#_Case_formulation) sections. For example, if a person has a headache (setting event), they may be more likely to react negatively to the presence of a trigger such as another person shouting.]

It is important to not only to state the triggers and setting events but also **why** they might lead to the behaviour. This will help the team come up with the function or purpose of the behaviour in the next section, ‘Functions’.

| Selection | Guidance |
| --- | --- |
| Activity | **Trigger**: Are there any activities, events or tasks that trigger the behaviour? Why? What behaviour will this lead to?  **Setting event** related to the trigger: What setting events directly relate to this trigger? What activities, events or tasks make it more likely that the behaviour of concern will occur? Why? |
| Communication | **Trigger**: Is there a particular form of communication or phrasing that triggers the behaviour (such as the word ‘no’)? Refer to the [Communication](#_Communication) part of the ‘About the Person’ section.  **Setting event**: What setting events directly relate to this trigger? What behaviour does this lead to? |
| People | Are there certain people whose presence or absence will trigger the behaviour (such as regular or casual staff)?  What is it about this person or group of people that triggers the behaviour? Is there a related setting event? What behaviour does this lead to? |
| Physical environment | Are there any environments or aspects of certain environments that trigger the behaviour or act as a setting event for the behaviour (such as noise, crowding, location, temperature, materials or objects in the environment)?  What behaviour does this lead to? |
| Place | Are there any locations (such as the pool, doctor’s waiting room) that trigger the behaviour or act as setting events? Why? What behaviour does this lead to? |
| Routine | Are there any changes to a particular routine or schedule that will trigger the behaviour? Are there related setting events? What behaviour does this lead to? |
| Time | Are there any times of the day or year that will trigger the behaviour? |
| Other | Describe anything else not already listed that may act as a trigger or setting event for the behaviour of concern. For example, being unwell or when experiencing symptoms of mental illness or another condition. |

### Functions

Select one or more of the following:

* seeking social interaction or attention
* what tangible objects or activities
* protest, avoidance or escape
* sensory processing
* physical needs

For every selection, a description is required under each heading.

**Note**: This section must be completed to meet the requirements of a BSP.

#### Behaviours occur for a reason

A behaviour that a person engages in repeatedly will typically serve some kind of purpose or function for them. Note the word ‘repeatedly’ is used because people engage in all kinds of behaviours but unless a behaviour serves a function for them it wouldn’t typically continue to occur.

All behaviours of concern serve a purpose or have a ‘function’. Correctly identifying the function of a behaviour can lead to effective strategies to support the person and to ultimately reduce the frequency, intensity or duration of that behaviour by teaching/replacing it with something that is functionally equivalent.

When we say the ‘function’ of a behaviour we basically mean ‘why’ the behaviour is occurring. While it might be difficult to understand why a person does something (such as behaviours of concern such as self-injury or aggression) there will always be an underlying function.

#### What is a functional behavioural assessment?

A functional behaviour assessment (FBA) is not one single thing; it is a broad term used to describe a number of different methods that allow researchers and practitioners to identify the reason a specific behaviour of concern is occurring.

These assessments are typically, but not exclusively, used to identify the causes of behaviours of concern such as self-injury, aggression towards others or destructive behaviours. An FBA seeks to analyse the individual, interpersonal and environmental variables that make an identified behaviour of concern more likely to occur.

Although there are different methods for carrying out FBAs, they all have the same goal: to identify the function of an identified behaviour of concern so that an intervention can be put in place to reduce this behaviour or increase more adaptive or functionally equivalent behaviours (or both).

An FBA undertaken across environments and settings can incorporate a wide evidence base, including a combination of some or all of the following;

* file audits
* a person’s history
* incident reports
* standardised interviews with the person and key stakeholders
* data recording
* direct and indirect observation.

#### What to include

What is the person trying to communicate by using a particular behaviour of concern?

**Important**:

* The function should logically link to the triggers and setting events and behaviours you have listed above.
* There can be multiple functions for one behaviour. For example, the person uses one behaviour for social interaction and the same behaviour to avoid something. Or the person may use multiple behaviours for the same function (such as kicks, bites and so on to avoid something).

Behaviours generally occur and are maintained by the following functions:

* social **attention**
* **tangibles** or activities
* **escape** or avoidance
* **sensory** stimulation

**Note**: This section must be completed to meet the requirements of a BSP**.**

| Function | Guidance |
| --- | --- |
| Seeking social interaction or attention | Is the person attempting to communicate their need to seek relationships, company or interaction with another person?  A person may engage in certain behaviours to gain some form of social attention or a reaction from other people. For example, a child might engage in behaviour to get other people to look at them, laugh at them, play with them, hug them or scold them.  While it might seem strange that a person would engage in a behaviour to deliberately have someone scold them it can occur because for some people it’s better to obtain ‘bad’ attention than no attention at all. |
| Wants tangible objects or activities | Is the person attempting to obtain a particular item or engage in a particular activity by using this behaviour?  Some behaviour occurs so the person can obtain a tangible item or gain access to a desired activity. For example, someone might scream and shout until their support worker lets them buy them a drink (tangible item) or takes them to the park to play cricket (activity). |
| Protest, avoidance or escape | Is there something the person wants to escape, avoid, reduce or delay by using this behaviour?  Not all behaviours occur so the person can ‘obtain’ something; often, behaviour occurs because the person wants to get away from something or avoid something altogether.  For example, a person might hit someone else so their support worker stops asking the person to clean their room.  Note that escape can be related to people (social) or places (environment). |
| Sensory processing | Is the person trying to seek or avoid, increase or reduce any sensory experiences (touch, taste, sight, sound, smell, movement or body awareness through muscles and joints)?  The function of some behaviours does not rely on anything external to the person and instead is internally pleasing in some way – they are ‘self-stimulating’ behaviours (O’Neill, Horner, Albin, Sprague, Storey, and Newton, 1997). They function only to give the person some form of internal sensation that is pleasing or to remove an internal sensation that is displeasing (such as pain).  For example, a person might rock back and forth because it is enjoyable for them while another person might rub their knee to soothe the pain after accidentally banging it on the corner of a table. In both cases, neither of these people engage in behaviours to obtain any attention, any tangible items or to escape any demands placed on them. |
| Physical need | Physiological or basic needs might include needing to use the toilet or wanting food or drink. |

# Section B: Treatment process

This section relates directly to the offending behaviour previously described and outlines the treatment for the offending behaviour.

Offending behaviour is the behaviour which has resulted in the need for the person to be detained (and the order applied for). It presents as a significant risk of serious harm to another person and often, but not always, results in involvement with the justice system.

## Offending behaviour

### Barriers to treatment

#### What to include

What are the factors involved that may be a barrier to treatment? These will need to be addressed for the treatment to be most effective.

**Note**: Include the barriers for treatment which may have been identified in the ‘[**About the person**](#_About_the_person)’ section. For example, motivation, substance use, comprehension or mental health.

### Skill deficits

The person needs to have the capacity for change.

Do they have the skills required to manage their risk without staff support?

This information is likely to be contained in the adaptive behavioural assessment. If this hasn’t been completed, consider if it needs to be completed during the life of this plan (under Section B).

#### What to include

This could include any skill the person wants to develop such as:

* social skills (like interacting with others)
* independence skills (like travel, cooking, using the phone or money)
* coping and tolerance skills (like relaxation techniques, mindfulness or waiting skills)
* problem solving

**Note**: Plans for building skills can link to barriers to treatment that you want to address. For example: teaching a person to manage impulsivity.

**The aim is to enhance the person’s skills to develop replacement behaviours and capacity to self-manage their own risk and achieve goals in a safe way.**

Replacement behaviours are behaviours the person can use to access their goals or meet the function of their behaviour, but in a safe manner.

**Note**: For some offending (type) behaviours, you may need to outline what you would like the person to do to reduce the risk of the behaviour occurring. The team needs to specify:

* the skills deficits
* the replacement behaviour to be taught so all staff can teach it and reinforce its use.
* how the replacement behaviour fills the same need (or function) that the particular behaviour of concern serves for the person
* who in the team will do what
* what strategies, tools or materials will be used to teach the replacement behaviour
* how the person will be rewarded with something positive to use the replacement behaviour.

**Note**: This section could be used as an action plan to outline how the priority treatment goals are to be implemented, measured and reviewed.

Section 191(7)(a): ‘specify the treatment that will be provided to the person during the period of the supervised treatment order’.

Section 191(7)(b): ‘state the expected benefit to the person of the treatment’

| Treatment goals | Treatment intervention | Benefits | Outcome measures |
| --- | --- | --- | --- |
| Some treatment goals will be identified in the risk assessment but there may however be additional goals in addition to those identified in the risk assessment.  A number of goals can be listed that should be the focus over the life of this Treatment Plan.  You can list them all but the Priority 1, Priority 2 and/or Priority 3 goals should be the ones that you will focus on over the life of this plan. | This is related to offence specific and related treatment (individual or group programs) which the client is to attend during the life of the Treatment Plan.  The intervention should lead towards the goal being met. | Record what are the expected specific benefits for the client if they engage in offence specific as well as offence related treatment and addressing their treatment goals.  You can have long term benefits, but you should also include specific benefits for this plan related to the treatment goals and the treatment intervention specified. This will allow you to measure progress and the success of your strategies.  **Note**: The benefits should be able to be measured. | How are you going to measure whether the treatment intervention has been successful or otherwise?  How will you know when a person has successfully mastered the treatment goal, or what their progress towards their treatment is?  What data and data collection methods are you going to collect to inform these questions?  The data will relate to the client’s dynamic risk factors, use of strategies, incidents, restrictive practices, successes or otherwise. |
| Priority goal 1 | List treatment interventions that link to priority goal 1 | List benefits to the person of treatment interventions outlined | List outcome measure for treatment interventions outlined |

### Review

Review processes should be collaborative and practice- and strengths-based (that is, using quality of life measures as a key review and using goal attainment scales).

#### What to include

What is your review process for:

* the implementation of treatment interventions
* the person’s progress in treatment
* the data collected and how this informs the strategies and interventions that are being used?

**Note**: It is important to consider with each individual client:

* what you are going to measure
* how you are going to measure it
* how you will use the data gathered.

For example, data will be collected, analysed and presented specific to the person’s risk, dynamic factors, use of strategies, incidents, use of restrictive practices, successes or otherwise at care team meetings, in implementation reports or as required.

## Behaviour of concern chosen

This section relates specifically to any behaviour of concern that has been entered, not the offending behaviour.

### Positive behaviour support

Positive behavioural support (PBS) is defined as ‘a multi-component framework:

* for developing an understanding of the challenging behaviour displayed by an individual, based on an assessment of the social and physical environment and broader context within which it occurs
* with the inclusion of stakeholder perspectives and involvement
* using this understanding to develop, implement and evaluate the effectiveness of a personalised and enduring system of support
* that enhances quality of life outcomes for the focal person and other stakeholders.’

Select one or more from the following:

* address triggers and setting events
* communication
* physical and mental wellbeing
* address [**About the person**](#_About_the_person) factors
* other

For every selection, a description is required under each heading.

**Note**: This section must be completed to meet the requirements of a BSP.

#### What to include

**Note**:To be effective, all support strategies need to:

* understand and address the function of the behaviour
* understand the reinforcement maintaining behaviours of concern
* mitigate the occurrence of the triggers and setting events which increase the likelihood of the behaviour.

Describe changes to be made now that should reduce the chances of the person needing to use the behaviour in the future, these should include:

* changes to be made to reduce or eliminate the triggers and setting events (changing an environment)
* identify consequences associated with the person’s behaviour (that is, reinforcement) and then enable the person’s access to the same reinforcement through alternative adaptive behaviours (replacement behaviours)
* teach a replacement behaviour which incorporates skill development
* addressing any physical and mental health issues, communication difficulties for the person and for staff, as well as the other areas of the person’s life needing support that were identified in the [**About the person**](#_About_the_person) section.

| Selection | Guidance |
| --- | --- |
| Address triggers and setting events | What needs to be changed in the person’s environment to reduce or eliminate the triggers or setting events or to minimise their impact?  What skills does the person need to learn to do instead of using behaviours of concern? |
| Communication | What communication supports does the person need to ensure successful two-way communication and how will this be implemented and maintained over time? |
| Physical and mental wellbeing | What does the team need to do to address any health issues? |
| Address ‘About the person’ factors | Address any other issues that were raised when completing the About the person section of this planning guide, such as environmental issues, lifestyle, relationships, sensory, disability, choice, and consider using person-centred active support. |
| Other | Use this section to address other issues that are not covered |

### Goals and objectives

Select one or more from the following:

* goals and objectives
* other goals.

For every selection, a description is required under each heading.

**Note**: This section must be completed to meet the requirements of a BSP.

#### What to include

This section relates specifically to any behaviour of concern that has been entered, rather than treatment goals to address offending behaviours.

For example, you may have a goal relating to a reduction in self harming behaviour.

| Selection | Guidance |
| --- | --- |
| Goals and objectives | * What will be achieved and when? * What behaviours (skills) will be increased? * What behaviours (of concern) will be decreased?   **Note**: This is your benchmark for when you will know if your strategies are working or not working. It must be evidence-based and reflect pre- and post-intervention data if at all possible. You are attempting to reduce or minimise the impact of previously identified behaviours of concern, measured against your initial definition and topographies (frequency, intensity, duration). |
| Other goals | Include goals for the other areas of this plan, such as skill development, physical and mental wellbeing and so on. |

### De-escalation

Select one or more from the following:

* assess safety
* prompt the replacement behaviour
* other
* post-incident debriefing

For every selection, a description is required under each heading.

**Note**: This section must be completed to meet the requirements of a BSP.

#### What to include

List what staff should do when each behaviour of concern identified occurs:

* to ensure the safety of all
* to avoid escalating the behaviour
* to minimise its impact on all people in the least restrictive way.

**Note**: For each behaviour or groups of behaviours, clearly state what the staff should do at each stage of behaviour escalation before the use of a restrictive practice is considered. The strategies listed need to work for the:

* person involved
* different places the behaviours may occur in
* staff who may have to use them.

| Selection | Guidance |
| --- | --- |
| Assess safety | Describe how staff should assess the safety of everyone before intervening. |
| Prompt the replacement behaviour | If safe to do so, how should the staff prompt the person to use the replacement behaviour being taught? |
| Other | The following de-escalation strategies may be useful:   * active listening * validation * provide need or want * remove cause * engage the person * apologise * provide verbal direction or verbal redirection * remove others * leave.   Section 191(7)(c): where a disability service provider has applied for an STO ‘specify any restrictive practices that are to be used’  **Important**: If the team plans to use a restrictive practice, the de-escalation section needs to state what the person’s presentation looks like to use that restrictive practice. That is, at what point you implement the restriction as well as the way that restrictive practice will be carried out.  Note what the person’s presentation looks like and match it to the staff response.  Section 191(7)(ca) contains similar provisions where a registered NDIS provider has applied for an STO: ‘specify any restrictive practices other than regulated restrictive practices to be used and the NDIS behaviour support plan should be attached.’  **Note**: The Victorian Senior Practitioner behaviour support plan is included in the treatment plan template and the restrictive practices used are authorised by the Victorian Senior Practitioner through the treatment plan certificate.  The About the person, Behaviours of concern, and the Restrictive practices for behaviours of concern sections **must** be completed. [end] |
| Post-incident debriefing | After any critical incident, describe how everyone will be de-briefed to ensure the wellbeing of all involved as well as learning how to do things differently next time to avoid another critical incident.  Best practice suggests there should be both immediate de-briefing and formal debriefing. The debriefings need to be done in a non-punitive and supportive way.  The immediate debriefing needs to look at the emotional support needed for the client and staff involved and any immediate changes required in the behaviour support plan.  The formal debriefing should occur within 48 hours of the incident and needs to examine the incident to discover the cause and what the team can change to reduce the likelihood of it happening again. This information should go into the person’s behaviour support plan and put into practice by the support team.  **Note**: The department’s [Resource guide for critical incident stress and debriefing in human service agencies](http://www.health.vic.gov.au/archive/archive2004/96ma124/) may be helpful <http://www.health.vic.gov.au/archive/archive2004/96ma124>. |

# Section C: Restrictive practices

Section 191(7)(c): where a disability service provider has applied for an STO, the treatment plan must ‘specify any restrictive practices that are to be used’.

Section 201B: states that ‘a disability service provider must not use a restrictive practice…unless a) there is a treatment plan in force and b) the treatment plan includes the restrictive practice’

Section 191(7)(ca): where a registered NDIS provider has applied for an STO, ‘specify any restrictive practices other than regulated restrictive practices to be used and the NDIS behaviour support plan should be attached’.

Section 201K: states that a registered NDIS provider must not use a restrictive practice on an NDIS participant unless a) there is a treatment plan in force…b) the proposed use of restrictive practices other than regulated restrictive practices is in the treatment plan and c) in the case of regulated restrictive practices, these are included in an NDIS behaviour support plan attached to the treatment plan.

Restrictive practice means ‘any intervention that is used to restrict the rights or freedom of movement of a person with a disability or of an NDIS participant.’

Regulated restrictive practices are:

* chemical restraint
* mechanical restraint
* seclusion
* environmental restraint
* physical restraint.

Restrictive practices may also include ‘other’ restrictive practices.

Restrictive practices need to be directly linked to a behaviour. They can be used to address offending behaviour, behaviours of concern or both.

All restrictive practices need to include the circumstances in which they will be used and include a range of use. That is, how will they be implemented and what is the minimum and maximum level that each restraint can be used. Use outside of this range will trigger a material change of the plan.

**Note**: This section must be completed to meet the requirements of a BSP.

## Restrictive practices that relate directly to offending behaviour

### Chemical – PRN administration

’Chemical restraint, which is the use of medication or a chemical substance for the primary purpose of influencing a person’s behaviour. It does not include the use of medications prescribed by a medical practitioner for the treatment of, or to enable treatment, a diagnosed mental disorder, a physical illness or a physical condition’. – NDIS Rules, section 6(b)

#### What to include

Medication that is not deemed a chemical restraint should be listed in the [**health section**](#_Health) in ‘[**About the person**](#_About_the_person)’ with clear indication what condition or illness it is treating. Ensure that conditions under 201D and E or, for an NDIS participant, 201K and L of the Disability Act are met

PRN chemical name (drug):

* dose – must be a measure, not ’drops’
* route (such as oral or injection)
* how often it can be given (frequency of doses)
* if more than one dose, how long to wait between doses
* maximum amount you can give in 24 hours
* maximum and minimum doses – what level of use is allowed within this plan (what level of use is reasonably foreseeable? Anything above this level of usage would be considered a material change)
* why the medication is prescribed – what is it targeting?
* how do you know if it has been effective?
* why the dosages would change
* prescriber’s name and job title

If the team plans to use a PRN restrictive practice, the de-escalation section needs to state what the person’s presentation looks like to use that restrictive practice. That is, at what point do you implement the restriction as well as the way (how) the restrictive practice will be implemented.

### Chemical – routine administration

#### What to include

Routine chemical name (drug)

* dose – must be a measure, not ’drops’ (Max: enter maximum, Min: enter minimum)
* frequency, such as mane
* prescriber’s name and job title

**Note**: The minimum and maximum values that are entered are often seen written as the ‘therapeutic range’

### Seclusion – PRN or routine administration

Under section 6(a) of the NDIS Rules, seclusion is ‘the sole confinement of a person with disability in a room or a physical space at any hour of the day or night where voluntary exit is prevented, or not facilitated, or it is implied that voluntary exit is not permitted where the person cannot get out.

**Note**: If seclusion is proposed over the life of the treatment plan, the necessary information for approval as specified under section 201D and section 201E or, for an NDIS participant, 201K and L of the Disability Act 2006 must be met.

An individualised seclusion protocol should be developed specifying these legislative requirements as well as the circumstances for implementation and cessation.

The maximum use of seclusion will need to be specified within the plan; however, the details of the implementation can be referenced (such as the seclusion protocol) within this section as an attachment to the plan.

**201D(a)**: Regulated restrictive practices, including seclusion, can only be used on a person

1. to prevent the person from causing physical harm to themselves or another person or
2. to prevent the person from destroying property where to do so could involve the risk of harm to themselves or any other person; and

**201D(b)** is the option which is the least restrictive as is possible in the circumstances.

For NDIS participants, section 201L sets out similar requirements for regulated restrictive practices, including seclusion.

Section **201L**: Regulated restrictive practices can only be used

1. if necessary to prevent an NDIS participant from causing physical harm to the NDIS participant or any other person and
2. is the least restrictive of the NDIS participant as is possible in the circumstances.

#### What to include

* Where seclusion will occur
* How long each episode can last (maximum time)
* How often the person will be checked
* How many times (maximum episodes) seclusion can be implemented within a time frame.

**Note**: The maximum time and frequency of seclusion needs to be reasonably foreseeable based on evidence.

The following information needs to be included.

The person’s specific behaviour support strategies outlining the circumstances which seclusion be used for treatment and the behaviours demonstrated for seclusion to cease.

Seclusion is not applied for longer than the shorter of the following periods:

* the period of time the APO has approved seclusion for
* the period of time during which the use of seclusion is necessary

Explain how the use of restraint or seclusion will be of benefit to the person.

Demonstrate that the use of restraint or seclusion is the option least restrictive of the person as is possible in the circumstances.

**201D(d)(i)** and **201L(d)** – the person is supplied with bedding and clothing which is appropriate in the circumstances and the person

* has access to adequate heating or cooling as it is appropriate in the circumstances
* is provided with food and drink at appropriate times
* is provided with adequate toilet arrangements

### Mechanical – PRN or routine administration

Mechanical restraint is the use of a device to prevent, restrict or subdue a person’s movement for the primary purpose of influencing a person’s behaviour; but does not include the use of devices for therapeutic or non-behavioural purposes – NDIS Rules, section 6(c).

#### What to include

Mechanical restraint can include (but are not limited to):

* belts or straps
* helmet
* bedrails
* cuffs
* gloves
* wheelchairs
* tables or furniture
* sprints
* restrictive clothing.

**Ensure that conditions under 201D and E (or 201K and L for an NDIS participant) of the Disability Act are met.**

Include:

* what is being used
* how is it being used
* how long each episode of restraint can last for (maximum time)
* how often the person will be checked
* how many times (maximum episodes) mechanical restraint can be implemented within a timeframe.

**Note**: The maximum time and frequency of mechanical restraint needs to be reasonably foreseeable based on evidence.

**Note**: An individualised mechanical restraint protocol can be developed specifying the circumstances for implementation and cessation. The maximum use of mechanical restraint will need to be specified within the plan; however, the details of the implementation can be referenced (such as the mechanical restraint protocol) within this section as an attachment to the plan.

### Environmental – routine administration

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

#### What to include

Restraint can include:

* locking a door, cupboard or knives to prevent a person’s access
* preventing access to a person’s possessions, such as mobile phone, tablet device (iPad) or lighter.

### Physical restraint – PRN administration

Physical restraint is the use or action of physical force to prevent, restrict or subdue movement of a person’s body, or part of their body, for the primary purpose of influencing their behaviour.

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

#### What to include

Physical restraint can only be used as PRN and does not include any prohibited physical restraints.

The following physical restraints are prohibited:

* prone restraint (subduing a person by forcing them into a face-down position)
* supine restraint (subduing a person by forcing them into a face-up position)
* pin downs (subduing a person by holding down their limbs or any part of the body, such as their arms or legs)
* basket holds (subduing a person by wrapping your arm around their upper and or lower body)
* takedown techniques (subduing a person by forcing them to free-fall to the floor or by forcing them to fall 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 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.

### Other restrictive practice – routine administration

Other restrictive practices include any restrictions on liberty other than chemical, mechanical restraint, physical restraint, environmental restraint and seclusion.

#### What to include

Ensure that conditions under 201D and E (or 201K and L for an NDIS participant) of the Disability Act are met.

## Restrictive practices for behaviours of concern (not offending behaviours)

| Regulated restrictive practice | Administration type | Guidance |
| --- | --- | --- |
| Chemical | PRN | See ‘[**Chemical – PRN administration**](#_Chemical_–_PRN)’ |
| Chemical | Routine | See ‘[**Chemical – routine administration**](#_Chemical_–_routine)’ |
| Seclusion | Routine or PRN | See ‘[**Seclusion – PRN or routine administration**](#_Seclusion_–_PRN)’ |
| Mechanical | Routine or PRN | See ‘[**Mechanical – PRN or routine administration**](#_Mechanical_–_PRN)’ |
| Other | Routine or PRN | See ‘[**Other restrictive practice – routine administration**](#_Other_restrictive_practice)’ |
| Environmental | Routine or PRN | See ‘[**Environmental – routine administration**](#_Environmental_–_Routine)’ |
| Physical | Routine or PRN | See ‘[**Physical restrain – PRN administration**](#_Physical_restraint_–)’ |

### Material changes

Section 195(1) of the Disability Act states that ‘the Senior Practitioner is responsible for a supervising the implementation of a supervised treatment order.’

Section 195(3) states that a change cannot be made to the plan unless approved by the Senior Practitioner.

Any changes to the person’s medication (of lesser or no change to the level of restrictions) that are added during the life of the plan are considered a variation to the approved plan and require the approval from the Victorian Senior Practitioner **before** implementation.

**Note**: Any increases in restrictions, beyond what has been the approved plan, requires the approval of the Victorian Senior Practitioner (if it is under an emergency situation) and VCAT under sections 195(4) and 195(5) or sections 195(5A) and 195(5B) for an NDIS participant.

# Section D: Supervision and supervising staff

Section 191(7)(d): the treatment plan ‘must state the level of supervision which will be required to ensure that the person participates in the treatment.’

The level of supervision in a treatment plan relates to the offending behaviour and is of such a high level that it constitutes detention.

Detain includes ‘constantly supervising or escorting a person to prevent the person from exercising freedom of movement’ – section 3.

## Offending behaviour

| Level of supervision | Ratio | Circumstances |
| --- | --- | --- |
| Current | 1:1 | A minimum and maximum level of supervision should be clearly articulated along with the circumstances: person’s presentation and environment, such as at home or in the community, in which you would use the minimum level of supervision and the maximum. |
| Maximum | 2:1 | Should there be an increase in such levels of supervision, there needs to be a clear rationale as to why and when this supervision arrangement would be used. This rationale should clearly articulate how this level of restriction is the least restrictive under the circumstances. |
| Other | 3:1 | Enter details |
| Other | ?:? | You can enter as many fields as required in this section. Consider all potential circumstances, such as education, work or day opportunities, holidays and so on. |

# Section E: Proposed reduction plan

Section 191(7)(e): The treatment plan must ‘set out a proposed process for transition to lower levels of supervision and, if appropriate, to living in the community without a supervised treatment order being necessary’

A reduction plan used to be in Part E of the previous plan. This is the plan for reducing supervision, including any restrictive practices as the client achieves their treatment goals within the term of the current treatment plan.

A step-down plan should include:

* the activities and events identified for reductions in supervision
* the steps or stages within each activity in terms of level of restriction
* the minimum timeframe required for each step
* criteria (behavioural indicators) that would lead to progression through each stage
* criteria (behavioural indicators) that would lead to possible backwards movements through the stages
* identification of decision-making processes and responsibilities in relation to progressing through step-downs

**Note**: Remember to ensure that the person’s step downs relate to activities that the person likes to do and will support them to reach their goals.

A key to step downs is to ensure that the person has the skills to be able to self-manage (including understanding of risk factors and being able to apply strategies to manage that risk) in the situation independent of staff. If this is unknown or the person does not have the skills yet, this should be prioritised as a treatment goal with clear review processes for measuring the person’s skill development. The demonstration of such skills should be the same as the behaviours that are required to be presented to progress through the step downs.

## Offending behaviour

| Reduction plan type | Guidance |
| --- | --- |
| Step down | * What is the current level of supervision or restriction the person is subject to – describe the conditions of this level of supervision. * What information supports the care team’s decision-making with regards to the person being able to progress through each step down?  For example, what behaviours must the person demonstrate or the number of occasions required for the person to practice the step, for supervision or restriction to be reduced? * What would you reduce it to? Describe the conditions of the first step down of lower levels of supervision. * Outline how many of these step downs you think would be reasonably foreseeable that the person could achieve over the life of this plan. |
| Step backwards | * What information supports the care team’s decision making that would warrant a backwards movement to an increase in supervision or restriction (up to the original maximum level outlined in the plan)? For example, what behaviours would the person demonstrate that indicates the person should not be at the level of supervision or restriction that they are subject to currently? How long would the person have to remain on the step backwards? * What behaviours does the person need to demonstrate over what period of time to return to the step they were previously subject to? * If it is reasonably foreseeable that the person may move backwards more than one step at a time what circumstances would this occur under? * Include parties that need to be notified if a person moves back to a higher level of restriction/supervision.   **Note:** All steps that result in higher levels of restriction or supervision should involve a discussion amongst the care team to review the person’s risk management strategies  It is good practice to advise the Senior Practitioner if the person has demonstrated behaviours that warrant consideration for backwards movement resulting in an increase in restrictions. |

### Material changes

Section 195(1) of the Disability Act states that ‘the Victorian Senior Practitioner is responsible for a supervising the implementation of a supervised treatment order.’

Section 195(3) states that a change cannot be made to the plan unless approved by the Victorian Senior Practitioner. Therefore, any additional step downs or changes to the plan (of lesser or no change to level of restrictions) that are added during the life of the plan, are considered a variation to the approved plan and require the approval from the Victorian Senior Practitioner before implementation.

**Note**: Any increases in restrictions (including additional backwards movement or changes in supervision arrangements) that are not already included within the approved plan, require the approval of the Victorian Senior Practitioner (if it is under an emergency situation) and VCAT under sections 195(4) and 195(5) or sections 195(5A) and 195(5B) for an NDIS participant.

# Who has been involved in the preparation of the plan?

| Name | Agency | Role | Relationship |
| --- | --- | --- | --- |
| The person with the disability |  |  |  |
| The person’s guardian if they have one |  |  |  |

**Note**: This section must be completed to meet the requirements of a BSP.

# Team coordination and review: measuring and reviewing client progress

## Team coordination

* How does the team coordinate the implementation of the plan?

**Note**: This section must be completed to meet the requirements of a BSP.

## Communication and review of goals

* When and how do goals get reviewed?
* What communication processes do you have in place to ensure that everyone has the information they need to implement the plan and support the person?

**Note**: Collaboration is critical to implementing a treatment plan. Therefore, all members of the care team (including the person) should be clearly listed here with each person’s role in supporting the individual subject to the STO or relevant order.

**Note**: This section must be completed to meet the requirements of a BSP.

# Treatment plan authorisation

| Agency | Service setting | Authorising user | Action | Date |
| --- | --- | --- | --- | --- |
| X - IT Test | Smith Congregate Care - Fitzroy, 145 Smith Street, Fitzroy | TEST | Created | 01/07/2021 |

# Appendix A: Addressing sections 191(6)(a to e) of the Disability Act 2006

VCAT can only make a supervised treatment order if VCAT is satisfied that the criteria laid out in section 191(6)(a to e) of the Disability Act have been met.

The following outlines the legislative criteria used to determine client suitability for a supervised treatment order (STO).

The disability service provider needs to establish that **all criteria** are met each time they apply for an order.

Intellectual disability

The person has an intellectual disability – s191(1)(a) or 191(1A)(b)

Evidence that the person has an intellectual disability needs to be presented.

Residential services

The person is receiving residential services s191(1)(b) or is an SDA resident living in an SDA enrolled dwelling provided under an SDA residency agreement s191(1A)(c)

### Evidence that the person is receiving disability residential services

Residential services are defined under section 3 of the Disability Act as a residential accommodation:

1. provided by or on behalf, or by arrangement with, a disability service provider
2. provided as accommodation in which residents are provided with disability services
3. supported by a rostered staff that are provided by a disability service provider
4. admission to which is in line with a process determined by the secretary.

### Evidence that the person is an SDA resident living in an SDA-enrolled dwelling provided under an SDA residency agreement

SDA-enrolled dwelling is defined in section 3 as a permanent dwelling:

1. that provides long-term accommodation for one or more SDA residents
2. that is enrolled as an SDA dwelling under the NDIS (SDA) Rules 2016.

SDA resident is defined in section 3 as a person who is an SDA recipient or a person who is a continuity of support (CoS) supported accommodation client.

SDA residency agreement means an agreement entered into or established under section 498F of the Residential Tenancies Act 1997.

Victorian Senior Practitioner approval

The Victorian Senior Practitioner has approved the treatment plan

The Victorian Senior Practitioner is responsible for approving the plan and will issue a certificate before attending VCAT for VCAT to consider the application for an STO.

Previous pattern of violent or dangerous behaviour

191(6)(a) The person has previously exhibited a pattern of violent or dangerous behaviour causing serious harm to another person or exposing another person to a significant risk of serious harm

Here the service is establishing that the person has a **history of a pattern of behaviour** that either causes or places other people at significant risk of serious harm.

* Previous offending or offending-like behaviour (excluding index offence) and any outcomes (such as recorded in notes, reported to police, interviewed but not charged, charged but not convicted, convicted, sentencing outcomes and so on)
* Can also include data on frequency, intensity and duration of behaviours that place other people at a significant risk of serious harm.
* VCAT decision ‘LM 9 October 2008’ defines serious harm as ‘physical or psychological injury, whether temporary or permanent, that endangers, or is likely to endanger human life, or is likely to be significant and longstanding’.

Significant risk of serious harm to another person

191 (6)(b) There is a significant risk of serious harm to another person which cannot be substantially reduced by using less restrictive means

This criterion looks to establish that there is a **current risk that has not been able to be managed** using less restrictive means.

* What is the current level of risk assessed as being? Describe or refer to risk assessment (previously outlined in Current offending behaviour. **Note**: that dealt with the assessment used and what the factors were that needed to be addressed in the treatment intervention section; this looks at the level of risk.
* What other less restrictive means to address the significant risk that the person poses to others have been tried? What was the outcome?

Treatment plan will benefit the person

191 (6)(c) The services to be provided to the person in accordance with the treatment plan will be of benefit to the person and substantially reduce the significant risk of serious harm to another person

Demonstrate that this plan is of **benefit** and attempts to manage the risk of significant harm.

Include a broad description of how the treatment plan as a whole will be of benefit to the person. Benefit in detail as it relates to each treatment intervention has been discussed within the plan and you can refer to that section for the finer detail.

The person is unable or unwilling to consent

191 (6)(d) The person is unable or unwilling to consent to voluntarily complying with a treatment plan to substantially reduce the significant risk of serious harm to another person; What does your assessment say?

Establish **either** that the person is ‘unable’ **or** is ‘unwilling’ to comply with the plan. This criterion requires positive evidence that the person is either unwilling or noncompliant.

* Has the person been assessed as being able to provide consent to complying with the treatment plan is the person willing to consent to complying with the treatment plan?
* Has the person shown over time through their behaviour that they are compliant with the treatment plan without the need for staff to enforce conditions of the plan?
* Describe times when the person has been non-compliant with treatment or has required staff support to comply
* In the VCAT decision ‘AC 8 May 2009’, VCAT determined that ‘the Tribunal has interpreted this provision as involving consideration if the person has “sufficient understanding” – an understanding that is more than superficial – so that consent may be regarded as real or reliable’.

Necessary to detain to ensure compliance

191(6)(e) It is necessary to detain the person to ensure compliance with the treatment plan and prevent a significant risk of serious harm to another person. What does your assessment say?

Has the person shown that they can comply with the treatment provided without the need for staff to detain them?

Are they reliant on external environmental measures (such as staff presence) to address their risk to others?

### Section 196 –Application for a review, variation, or revocation

**Note**: if the APO is seeking revocation of the person’s STO, under section 196(8)(a) VCAT must be satisfied that any of the matters specified in section 191(1) have ceased to apply to revoke the STO. Therefore, an application for revocation needs to clearly demonstrate which criteria the person no longer meets.

Sections 193(2) and196(9) state that VCAT cannot confirm the STO unless VCAT is satisfied the disability service provider can implement the STO or variation to a plan, if an application for a review or variation was made. This highlights how critical the planning and coordination of these plans are before getting to VCAT, to ensure the service’s ability to implement the plan.