Ability Consultants
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Dear Department of Communities and Justice

We are an organisation providing behaviour support services to NDIS recipients throughout Australia. We are passionate about maximising freedom and social connection for people through easy access to Positive Behaviour Support services. Part of this includes a passion for reducing and eliminating the use of restrictive practices. We are excited by the opportunity to have a say on the Consultation Paper you have made available. Within our organisation, we have a group of practitioners with a specific interest in restrictive practices and we have consulted this group to gather their thoughts on the questions you have posed in this paper. We hope that our perspective is useful in helping create an efficient and effective system for handling restrictive practices in the State of NSW.

Question 1: Should the proposed legislative framework cover the out of home care setting?

Our Response: Yes, however, the impact on NDIS behaviour support providers needs to be considered as we need to meet NDIS RP rules. If we identify barriers in service delivery, e.g. training, implementation, the reporting requirements will increase our workload, i.e. having to report to another government body about barriers and challenges.

Question 2: Should the proposed legislative framework cover any other setting?

Our Response: Yes. Health, Education and Justice settings should be included. However, it should be recognised that extending the framework into these areas would involve a great deal of work and interdepartmental cooperation which may be difficult to achieve

Question 3: What issues and challenges are raised by there being different frameworks for the authorisation of restrictive practices in the disability service provision setting and the aged care setting?

Our Response: Confusion, errors, and more importantly, human rights abuses are more likely when different rules apply to different settings. While it is the case that there are differences in the ways that different settings generally run, if we are serious about the human rights and safeguarding of people with disabilities, these concepts are universal, so the rules and the system supporting these rules need to hold all parts of society to the same standard

Question 4: Do you support legislation requiring that restrictive practices on NDIS participants in the disability service provision, health, education and justice settings should be governed by the principles recommended by DRC Recommendation 6.35(b)?

Our Response: Yes and no. We support common legislation covering the use of restrictive practices in these settings, but the DRC Recommendation 6.35(b) contains many elements, and we're not sure that absolutely all of the elements should be enacted in NSW (See below for details of our thoughts on these elements)

Question 5: Are there any other principles that should be considered?

Our Response: The principle of upholding human rights should be at the forefront of our thoughts when considering how we can best design a system around restrictive practices. There is a temptation to respond to the challenge of upholding human rights with additional oversight, but this has a downside, in that the more oversight there is the more reporting and paperwork is usually involved, and there is a point where the focus on paperwork actively gets in the way of actually fading the use of restrictive practices. Presence in the settings by people independent of the settings, perhaps via a well resourced community visitor program run by the Senior Practitioner, is more likely to pick up potential human rights abuse than is a set of extensive reporting requirements.

Question 6: Should a legislative framework prohibit any practices? If so, which practices and in which settings?

Our Response: Yes. For the most part, the principle we would support is that it should prohibit those practices which are identified by the NDIS Quality and Safeguarding Commission as High Risk Restrictive Practices.
Having said that, we think there needs to be a discussion about the boundaries of "practices that limit or deny access to culture", in terms of what specific practices this encompasses and whether the risk involved in these warrants prohibition. We also think that the use of Response Cost as a parenting strategy in Australia is near universal. While we would argue that it's against the principles of PBS and should never be included in a behaviour support plan, we think it's highly problematic to prohibit its use while the community standard so clearly includes acceptance of this practice across society.

Question 7: Do you agree that:
• the framework should use the NDIS definitions of restrictive practices?
• the Senior Practitioner should have the power to issue guidelines that clarify how the definitions apply in different situations?

Our Response: Yes, the framework should use the NDIS definitions of restrictive practices, including as they are defined in supplementary material produced by the NDIS Quality and Safeguarding Commission, such as the Safe Transportation Practice Guide. There should be a single source of information about what constitutes a Regulated Restrictive Practice, and the framework's scope should only extend to practices within these definitions.

No, the Senior Practitioner should not have such power to issue guidelines of this nature. There should be a single source of information about what constitutes a Regulated Restrictive Practice, and the issuing of alterations to this should not be within the power of the states. Should the Senior Practitioner see the need for such clarification, we would strongly advocate for the Senior Practitioner and the NDIS Quality and Safeguarding Commission to forge a strong and close working relationship for such needs to be voiced to the Commission, who would then be the source of any such clarification.

Question 8: What role should the Senior Practitioner play in regulating behaviour support plans? For example:
- *Should the Senior Practitioner have the power to prescribe additional and/or more detailed information for inclusion in the BSP? If so, what information?*
- *Should the Senior Practitioner have the power to require a behaviour support practitioner have certain qualifications and the Senior Practitioner's approval before they can prepare a BSP which will be used to authorise the use of a restrictive practice? If so, what should the additional qualifications and criteria for approval be?*
- *Should there be any specific provisions relating to consultation in the development of a BSP, in addition to the requirements in the NDIS Rules?*

Our Response: No, the Senior Practitioner should not have the power to regulate behaviour support plans. There are already extensive regulations from the Commission about what needs to be in a behaviour support plan, and another set of regulations is unlikely to produce better results. If the Senior Practitioner is seeing a trend of certain information being absent from many plans, they should seek to work with the Commission to ensure that the Commission's guidelines include the elements deemed most important.

The Senior Practitioner should have no power to dictate the contents of a behaviour support plan. The Senior Practitioner cannot be the Behaviour Support Practitioner for every single person requiring behaviour support services in the state, and without having a thorough understanding of the individual, their circumstances and the human life they are living, the Senior Practitioner is not in a position to know what is right or wrong to be in an individual's behaviour support plan.

No, the Senior Practitioner should not add requirements for approval to be a behaviour support practitioner. There are already regulations in place requiring behaviour support practitioners to register with the NDIS Quality and Safeguarding Commission, to be deemed suitable by the Commission, and to evaluate their skills and knowledge against the Capability Framework. Adding another layer of registration or requirements on top of this can only serve to further thin the market of available and competent behaviour support practitioners. If the Senior Practitioner feels that further requirements should be imposed on behaviour support practitioners in terms of qualifications, this should be raised and negotiated with the Commission

No, the Senior Practitioner should not dictate provisions around consultation. The rules already state that consultation is a requirement. Should the Senior Practitioner be of the opinion that these requirements are insufficient, this should be discussed with the Commission.

Question 9: Is there anything else the proposed framework should do to improve the quality of BSPs?

Our Response: There are existing resources which are available to promote the production of good quality behaviour support plans. It may be helpful for the Senior Practitioner to have a role in curating a list of such resources so they are easily accessible to all behaviour support practitioners across the state.

Question 10: Should Authorised Program Officers (APOs) be empowered to either:
• authorise particular categories of restrictive practices without separate Senior Practitioner authorisation (a partially delegated model). If so, what categories of restrictive practices should be able to be authorised by APOs? Should these be prescribed by legislation, or through class or kind orders?
• provide preliminary approval of restrictive practices, with final authorisation provided in all cases by the Senior Practitioner (a two step model)? What would be the benefits and risks of the above models?

Our Response: The main benefit we can see to the APO model is that there will be specific people on the ground across implementing providers with a focus on restrictive practices.

The risks are many, including a massive issue around conflict of interest, resourcing issues around smaller providers being unable to afford to employ one, the logistics of ensuring that the APOs receive adequate initial and ongoing training and resources to do their jobs effectively, etc. The APO model does not seem likely to unearth any actual human rights abuses, but may serve to streamline the authorisation system somewhat. Because of the high levels of risk and relatively low apparent benefit, we're leaning towards the two step model, where APOs provide interim authorisation and Senior Practitioner considers final authorisation. We would like to strongly encourage designing a system which works in with the existing systems, so perhaps it would make sense for APOs to authorise Interim Behaviour Support Plans and the Senior Practitioner to authorise Comprehensive Behaviour Support Plans.

Question 11: Are there alternative approaches to authorisation that would be preferable to these models?

Our Response: If the Senior Practitioner were resourced with a sufficient workforce to enable site visits as part of the process, and that this site visit was the mechanism by which it was determined whether the practice should be authorised or not, this system would allow a much more efficient identification of potential human rights abuses, and a reduced focus on documentation and administrative tasks. In addition, some of our team advocate for the inclusion of an expert in decision-making e.g., doctor for chemical restraint

Question 12: Should APOs be required to be employed by a single provider? Or should APOs be permitted to be consultants to a number of providers? If so, what safeguards should there be in relation to this?

Our Response: Realistically, smaller providers would not have the means to employ their own APO, and the requirement to do so would most likely disadvantage people with disabilities by limiting their choice of providers. As such, if the APO model is used, it would need to allow for at least some providers to access the same APO as a consultant. This would unfortunately create a situation where providers are paying per authorisation, which would potentially intensify the inherent conflict of interest issues.

Question 13: Do you support the proposed duration of authorisation and emergency use proposals for restrictive practices?

Our Response: The proposed duration represents no change from what is currently in place, and is in line with the NDIS requirement to update the plan at least annually, so this proposal makes sense.
The proposal that there should be an emergency use process before the development of a behaviour support plan to replace the interim authorisation process does not appear to line up with federal requirements, and is likely to cause confusion. It is important that the state-based authorisation system works in harmony with the processes laid down by the Commission. Practitioners are expected to produce an Interim Behaviour Support Plan within one month of allocation if restrictive practices are in use, and the authorisation process should follow the same timeline and expectation of documentation.

Question 14: Are there any additional grounds on which the Senior Practitioner should be able to cancel an authorisation?

Our Response: Ideally, the decision to cancel authorisation of a restrictive practice should be based primarily on the determination that the use of the practice represents a breach of the person's human rights which outweighs the safety benefits. The concept of there no longer being a need for the practice should be based on this consideration.

Importantly, the concept of removing authorisation for a practice for administrative reasons is dangerous and counter to the principle of safeguarding the person. Specifically:

- If the evidence provided is deemed unsatisfactory, the response should ideally be a visit to the person in their home to make a determination of the need for the practice, not the removal of authorisation for a practice which there may be a good reason for.
- If the authorisation was obtained with incorrect or misleading information, the response should be to take action to sanction the provider of that information, but it is potentially dangerous to use removal of authorisation for restrictive practices as this sanction.
- If a provider contravenes a condition of authorisation, this should be referred to the Commission for investigation. Again, it is dangerous to use removal of authorisation as a tool to sanction people who have done the wrong thing. Authorisation should be first and foremost about protection of human rights, not an administrative exercise.
- If a service provider contravenes a provision of the legislation, this should surely result in legal action directly relevant to the aspect of the law contravened, not a blanket assumption that the authorisation should be revoked.
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Restrictive practices are generally in place to keep a person safe. Removing the authorisation to keep a person safe is by its nature a dangerous proposition, and doing so should be done with consideration to the person's quality of life, not the meeting of administrative or legal requirements.

Question 15: Should authorisation decisions: • be open to internal review? • be reviewable at NCAT?

Our Response: Any process which relates to human rights and safeguarding should be open to review. It makes sense for the first level of review to be an internal process and subsequent levels to be external. I hold concerns about the potential stretching of NCAT resources for this purpose, and wonder whether it is in the system's best interests to load this already stretched resource up with this additional responsibility.

Question 16: Should rights to seek review be limited to the person or a person concerned for their welfare? Should the service provider have a right to seek review of a decision not to authorise a restrictive practice?

Our Response: I find it interesting that service providers are deemed separate to people concerned for the individual's welfare. If a service is deemed to be unconcerned with a person's welfare who is in their care, I would like to think that would be a massive red flag and action would be taken to ensure the person is safely supported. I think that if there is to be a review process, it should apply to all decisions made, whether that is to authorise the practice or not.

Question 17: Should a person have a right to request the service provider review the BSP at any time?

Our Response: We're confused by this proposal. Is the suggestion that an implementing provider of direct supports should undertake a clinical review of the behaviour support plan? We would question how many providers would have the clinical knowledge to do so. A behaviour support plan should already include consideration of whether the practice is necessary and what less restrictive options should be tried, as well as strategies to reduce and eliminate the practice and environmental changes. If it doesn't, adjustment of the plan to include such details should be a condition of authorisation. Any review should include the behaviour support practitioner, and there is already a federal mandate for the practitioner to update the plan as things change. We don't understand the value of a review of the plan by a person who potentially lacks the skillset to conduct this review competently.

Question 18: Should the Senior Practitioner have complaints handling and investigation functions either on receipt of a complaint, on its own motion, or both?

Our Response: The Senior Practitioner must have the capacity to handle complaints made about it, as must all services for people with disabilities.

However, the handling of complaints about other services and the use of restrictive practices is the responsibility of the Commission. Complaints relating to the use of restrictive practices and the quality of behaviour support planning should be referred to the Commission, either by redirecting the complaint, or by receiving and passing on the complaint. The creation of another level of complaint handling creates a confusing situation for everyone involved where it is uncertain who the complaint should be directed to, and also a potential doubling of the workload required to make a complaint to both bodies. Any investigation initiated by the Senior

Practitioner should be done at the request of the Commission to assist in gathering information to complete its work.

Question 19: Do you agree the Senior Practitioner should have the proposed powers to respond to misuse of a restrictive practice?

Our Response: Potential abuses of human rights should be the Senior Practitioner's primary focus. If the Senior Practitioner is to exercise powers such as those proposed, they should be focussed on informing the Commission of actual abuse, neglect, or exploitation of people with disabilities, regardless of whether this relates to restrictive practices. Any action taken as a result of the exercising of such powers should be in the direct service of safeguarding people with disabilities.

Question 20: How should interaction with the NDIS complaints framework be managed?

Our Response: Any exercising of such powers should be done collaboratively with the Commission, as part of a close partnership between state and federal authorities to safeguard the human rights of people with disabilities. The Senior Practitioner should not have the right to act in isolation from the Commission on such matters.

Question 21: To which bodies should the Senior Practitioner have the power to share information and in what circumstances should the Senior Practitioner be permitted to share information?

Our Response: The privacy of people with disabilities should be upheld as a default. Information should be shareable with the NDIS Quality and Safeguarding Commission, in cases where knowledge held by the Senior Practitioner would assist the Commission in the safeguarding of a person with disability. The police, where law has been contravened. Child protection services, where a child is deemed to be at significant risk of harm.

Question 22: Are the means by which the Senior Practitioner would have visibility of the use of restrictive practices by NDIS providers proposed in this Paper sufficient? If not, what additional information should providers be required to report to the Senior Practitioner? How can reporting burden to the Senior Practitioner and the NDIS Commission be minimised?

Our Response: The monthly reporting requirement represents a doubling of work required by behaviour support practitioners and implementing providers, and as such is an extremely inefficient process which would place a significant burden on taxpayer-funded services. As part of a close alliance with the Commission, the sharing of data already being collected should be a possibility. We would anticipate that the doubling of reporting requirements would serve to cause services to seek to conceal use of restrictive practices. It is also possible that the additional administrative burden may cause the cessation of operation of some smaller service providers, which would serve directly to limit the choice and control available to people with disabilities.

A robust and well-resourced community visitor programme run through the Senior Practitioner would allow auditing of records kept on the premises, including viewing data relating to the use of the practice. Furthermore, the accuracy of this data could be certified by direct observation of the environment and interactions relevant to the practice.

Question 23: Do you agree the Senior Practitioner should have the proposed education and guidance functions?

Our Response: The provision of information about restrictive practices to people with disabilities, their families and the broader community would be a useful function, but the information provided must be in 100% agreement with the information available from the Commission.
The Commission currently holds a function to develop guidelines and standards around behaviour support planning and restrictive practices, and as such, the Senior Practitioner should definitely not have such functions. There needs to be a reliable, single set of true information about restrictive practices and behaviour support planning standards. The creation of a second set of guidelines and standards around this would serve to confuse the behaviour support practitioner community, and is more likely to result in a reduction of quality of work as practitioners scramble to understand and meet two sets of standards. If the Senior Practitioner holds an opinion that the work of the Commission in this space is inadequate, they should aim to contribute to the Commission's guidelines and standards, not to unilaterally create their own.

Question 24: Should the Senior Practitioner have the power to impose sanctions for the misuse of restrictive practices, or are existing sanctions for misuse of restrictive practices sufficient? How should the interaction between sanctions provided for under NDIS legislation and the proposed framework be managed?

Our Response: The Senior Practitioner should act in collaboration with the Commission and police to ensure any relevant sanctions are used. If the Senior Practitioner deems the available sanctions inadequate, they should seek to collaborate with these bodies to consider the creation of a set of further sanctions.
Without more information about what sanctions are being proposed, it is impossible to say whether this is a reasonable proposal. As an extreme example, if the proposal is that a service provider be publicly flogged for locking a cupboard they weren't supposed to lock, no, we don't think that's reasonable.

Question 25: Should the proposed framework provide for a legislated immunity from liability from the use of restrictive practices where the use was in accordance with an authorisation and done in good faith?

Our Response: From the text in this paper, it appears that the determination about whether or not something was done in good faith is in the application of the criteria that the action is in line with the behaviour support plan and in the context of authorisation. Assuming that is the proposed criteria, a question remains of what protections might be in place for using unauthorised practices which were necessary in the maintenance of duty of care. For example, is there a similar protection available for a support worker who saves a person's life by physically escorting them away from a busy road they were about to walk onto when there is no behaviour support plan in place and no authorisation to restrain the person?

Further to this, it is unclear at what point this act would be deemed to be in bad faith, and how the intentions of the support worker would be determined. We're unsure whether determining whether an action is in good faith is possible, and therefore it is predictable that legal protections would be applied inconsistently and based on subjective assessment. As such, we have reservations about how this would be implemented, but we agree philosophically that a worker acting in good faith and to the best of their ability in the interests of the person with disability should not be subject to legal proceedings against them relating to that action. Further to this, considerations about the actions of a NDIS registered service provider worker would be the concern of the Commission.

Question 26: Are there any other functions which the Senior Practitioner should have? Should providers in the disability service provision setting be subject to any other requirements?

Our Response:
As previously stated, the Senior Practitioner should have a significant on the ground presence via a robust and well-resourced community visitor programme. The human rights of people with disabilities should be prioritised, and administrative tasks should be minimised where possible. The authorisation of restrictive practices should be the primary function of the Senior Practitioner, and any further functions or powers should not duplicate existing frameworks, but should work closely alongside them with a consistent and clear focus on completing its primary function in the interests of upholding the human rights of people with disabilities.

Yours Sincerely,

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