Ability Options

Response to DCJ Consultation Paper

A legislative Framework to Regulate Restrictive Practices

14/03/2025

Ability Options Response to Consultation Paper: A legislative framework to regulate restrictive practices

Questions

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

Yes. Successful implementation of the framework is intended to reduce and eliminate restrictive practices in NSW thereby improving the quality of life of people with disability and protecting their human rights to freedom and autonomy; Ability Options in accordance with our mission and values would like to see this framework extended to all people with disability who experience restrictive practices irrespective of the setting in which they are implemented – subject to our recommendations that the framework does not redirect further unfunded organisational resources to reporting activities alone.

A child that is cared for in an OOHC setting is at risk of significant impact when experiencing a denial of their human rights. The risk remains the same to the child whether the practice is implemented in foster care, kinship care, family group homes, residential care or independent living. Increasing and streamlining regulation of restrictive practices and behaviour support across these living arrangements should be prioritised by the NSW State Government.

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

Ultimately, we believe the NSW State Government should strive to extend the framework to cover all settings where people with disability receive funded supports and services including within the aged care setting. A nationally consistent legislative framework would further support this endeavour.

We understand the framework will be applicable to its full extent within the disability service provision setting which covers the provision of NDIS funded services which NDIS providers provide to NDIS participants. We are pleased to read that the disability service provision setting will cover all providers whether registered or unregistered thus capturing providers who may operate in regional and remote locations where exceptions to registration may exist.

Whilst the framework is focussed on NDIS participants currently, Ability Options provides support to people who are funded through other schemes such as iCare who are subject to restrictive practices. DCJ acknowledges the definition of the disability service provision setting will evolve with the roll out of Foundational Supports in NSW and as such we would hope that the definition will also evolve to include people with disability who are funded through other schemes ensuring people are afforded the same protections of their human rights regardless of the source of their funding.

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?

- Less regulatory oversight of the implementation of restrictive practices in the aged care setting despite the risks to the individual being the same and by that same token less education and guidance provided to the aged care workforce.
- Less transferrable skills and best-practice knowledge which can hinder cross-pollination of workers between various settings, creating micro-cultures within settings.
- Training is left to individual providers in different settings and can vary greatly in quality – could be consistent across all settings if framework was the same nationally or at least at a state level (i.e. opportunity to expand on the NSW Industry Skills Accelerator micro-credentials – skills passport)
- Ultimately, less human rights protections to people living in aged care settings.

Proposals

Proposal 1: Legislation should provide that the use of 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).

Proposal 2: The legislation should require government agencies in the health, education and justice settings to provide an annual report to the Senior Practitioner on their, and their contractors', compliance with the principles.

Questions

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)?

Yes. As above, the State Government should look to extend the legislation, as governed by the principles recommended by the DRC, to cover health, education and justice settings. Consistency in legislation across all settings where people with disability interact, will afford better protections of their human rights and strengthen community understanding regarding the impact of the use of restrictive practices on people with disability irrespective of the setting in which it occurs.

We understand that health, education and justice settings will not be subject to the full extent of the proposed framework and will not be required to seek authorisation of restrictive practices from the Senior Practice in their respective settings, instead being required to submit an annual report regarding their use of restrictive practices – the details of which have not been provided yet.

Whilst some settings may be accessed in a more transitory fashion than others by people with disability (such as the health setting) – which would pose challenges for gaining authorisation as described in this framework – there remains very limited regulation and oversight by the Senior Practitioner on the use of restrictive practices and, more concerningly, the use of prohibited practices within these settings because they are not subject to more regular reporting requirements.

Ability Options calls for more information on how the proposed framework intends to protect people with disability from prohibited practices in health, education and justice settings above and beyond the requirement for an annual report from each. For example, would the Department of Education's Professional and Ethical Standards branch be required to report instances of physical intervention directly to the NDIS Quality & Safeguards Commission or the Senior Practitioner, either of whom may be able to impose sanctions or refer to NSW Police?

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

Expanding the principle which refers to restrictive practices being proportionate to include the principles of trauma-informed support and dignity of risk.

Question

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

Ability Options understand the NDIS Quality and Safeguards Commissioner currently has a function of assisting states and territories to develop a regulatory framework for restrictive practices. We agree that an important step in developing that framework is national agreement on a list of restrictive practices that should be prohibited by states and territories. In December 2018, the NDIS Commission developed a list of practices proposed to be prohibited taking into account states' and territories' existing guidelines and practice advice regarding restrictive practices. In May 2019, the list was agreed to by the National Senior Practitioners Practice Leadership Group and submitted to the Senior Officials Working Group for agreement. In December 2019, the Disability Reform Council endorsed the prohibited practices as listed in Appendix B of this Consultation Paper regarding the new legislative framework:

Specific forms of physical restraint

a) The use of prone restraint, which is subduing a person by forcing them into a face-down position.
b) The use of supine restraint, which is subduing a person by forcing them into a face-up position.
c) Pin downs, which is subduing a person by holding down their limbs or any part of the body, such as their arms or legs.

d) Basket holds, which is subduing a person by wrapping your arm/s around their upper and or lower body.
e) Takedown techniques, which is subduing a person by forcing them to free-fall to the floor or by forcing them to fall to the floor with support.
f) Any physical restraint that has the purpose or effect of restraining or inhibiting a person's respiratory or digestive functioning.
g) Any physical restraint that has the effect of pushing the person's head forward onto their chest.
h) 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

<u>Punitive approaches</u>

a) Aversive practices, which is any practice which might be experienced by a person as noxious or unpleasant and potentially painful. For example, threats, deliberate cold baths, applying chilli powder to the hands to prevent biting, sitting on a person to prevent them from self-harming.
b) Overcorrection, which is any practice where a person is required to respond disproportionately to an event, beyond that which may be necessary to restore a situation to its original condition. This is often used as a punitive measure. For example, a child draws all over their desk at school and they are made to clean the whole classroom.
c) Denial of key needs, which is withholding supports such as owning possessions, preventing access to family, peers, friends and advocates, or any other basic needs or supports. For example, denying access to basic needs such as toilet paper, sanitary items, stopping a person from seeing their friends or family.
d) Practices related to degradation or vilification. For example, practices that are degrading or demeaning to the person; may be perceived by the person or their guardian as harassment are unethical.
e) Practices that limit or deny access to culture. For example, actions that limit participation opportunities or access to community, culture and language, including the denial of access to interpreters.
f) Response Cost, which is a punishment of a person who forgoes a positive item or activity because of the person's behaviour. For example, a planned outing is cancelled because the person did not follow the morning routine

The Council also agreed to prioritise efforts towards attaining national consistency, guided by shared principles for restrictive practice authorisation.

In NSW, the current Restrictive Practice Authorisation Policy (2019) prohibits:

- aversive practices.

- overcorrection.
- the misuse of medication.
- denial of key needs.
- seclusion of children and young people under the age of 18.
- unauthorised use of restrictive practices; and
- any act in any way which: degrades or demeans a person, may reasonably be perceived by the person as harassment or vilification, or is unethical.

In NSW the Children and Young Persons (Care and Protection) Regulation 2012 further prohibits for person's aged 18 years and under:

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

Ability Options would welcome the nation-wide adoption of the Disability Reform Council's list of prohibited practices across all settings on the condition that the list, which should act as a single source of truth nationally, is expanded to include prohibited practices specific to certain situations and cohorts (e.g. young persons and people with psychosocial disabilities) which may be designated through class or kind orders.

Ongoing consultation and co-design with impacted cohorts is strongly encouraged.

Proposals

Proposal 3: The NDIS definitions of restrictive practices should be adopted for the NSW legislative framework for restrictive practices.

Proposal 4: The Senior Practitioner should have the power to issue guidelines that clarify how the definitions apply in different situations.

Question

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?**

Ability Options supports the framework using the NDIS definitions of regulated restrictive practices to ensure national consistency across all relevant settings. Disability Service Providers currently implementing restrictive practices, who will be subject to the full extent of the proposed framework for authorising restrictive practices, are already operating with these definitions and will have built policy, process and practice training around them to support their adherence to the regulatory requirements of the NDIS Quality and Safeguards Commission.

The effects of using restrictive practices can be varied and impact people differently. This can depend on the type of practice, how it is used, how long it is used and the history and understanding of the person.

We support the Senior Practitioner having the power to issues guidelines that clarify how definitions apply in different situations insofar as they will hold a guidance and education function crucial to the reduction and elimination of restrictive practices in NSW.

An example of where this power would be of benefit is in the regulation of chemical restraint where the true purpose of medication (and effective strategies to mitigate the risks of overprescription and polypharmacy) may be missed based on incorrect (or inappropriate) use of the Purpose of Medication form to circumvent reporting requirements (developed by the NDIS Quality & Safeguards Commission). The practice of seeking Independent Psychiatric Review will be further compounded by the possible lack of active psychiatrists in NSW.

Another example would be in the Adult Justice System where there is currently no formal framework for identifying, tracking, authorising, or reviewing restrictive practices despite a disproportionate number of people within this system having an intellectual disability.

A third example would be in relation to the use of mechanical restraints during transport.

Ongoing consultation and co-design with impacted cohorts is strongly encouraged.

Questions

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?

Regulation plays a critical role in providing a mechanism for protecting some of our most vulnerable members of community from poor or unethical practice. There are significant risks associated with challenging behaviours and the impacts of unregulated practice can be detrimental for the person.

Our experience echoes that of this study which found the current behaviour support workforce to be largely unregulated and inexperienced despite the weight of responsibility associated with the work (Positive behaviour support under the National Disability Insurance Scheme in Australia: Barriers, enablers and support needs from the perspective of practitioners).

Ability Options supports further regulation of behaviour support practitioners by a professional body which addresses the need for access to quality training and clinical supervision as well as barriers relating to inconsistent funding in the context of resource-heavy compliance activities.

Despite the NDIS Quality & Safeguards Commission being responsible for the capability framework of practitioners, the disability sector is significantly under-resourced with respect to experienced behaviour support practitioners, meaning that people with disability either wait lengthy times or are unable to access good PBS. This also directly contributes to increased compliance activities for disability providers.

There is currently an independent review underway by Flinders University of the NDIS Quality & Safeguards Commission PBS Capability Framework and assessment process for behaviour support practitioners to better help decide who can be a NDIS behaviour support practitioner. Providers will be invited to provide their feedback. We expect the findings of this review will also be taken into consideration when determining the role that the Senior Practitioner plays in regulating behaviour support.

It may be appropriate for the professional body that regulates behaviour support practitioners to sit outside of the Senior Practitioner's direct scope (which appears to be exceptionally broad). The Senior Practitioner should be consulted on the professional requirements, qualifications and criteria which should be expected of behaviour support practitioners in line with their education and guidance function. It would be the responsibility of the professional body to then develop and implement accredited PBS training programmes, with standardised benchmarks and credentials for PBS practitioners (consistent with other professions) to ensure a skilled and qualified workforce. As per the investigations function of the Senior Practitioner. they may refer matters to the regulator regarding unprofessional, unethical practice.

As a registered disability service provider, responsible for the implementation of behaviour support plans, we would like to see:

- The provision of BSP's in accessible formats, using easy English. This would also be of benefit to support teams who are also implementing the plan.
- Clear *implementation* plans to support staff with implementing a plan across a maximum period of 12 months. This should also include training plans.
- Clear prescriptions for data collection and provision of aggregated data from the behaviour support practitioner to the provider to support efforts to reduce and

eliminate restrictive practices. Practitioners use of data to inform BSP's should be regulated.

- Interaction with medical prescriber of psychotropic medications – requirements for data aggregation to be provided prior to psychiatrist appointment to advise the medical officer of any changes, trends in the behaviours of concern in order to work towards titration and reduction.
- Increased transparency and accountability in funding allocations to ensure clear guidelines and reporting mechanisms to track resource utilisation and promote efficient use of funds. Practitioner use of funding should be regulated.
- Broader adoption and promotion of specific resources that promote consultation and supported decision making such as Deciding with Support: Deciding With Support – Holistic supported decision making toolkit designed for people with disability, supporters, practitioners and service providers.
- Clear steps taken by the practitioner to ensure adequate consultation throughout the course of developing and reviewing the BSP.
- Includes communication profile as standard and completed in collaboration with allied health specialists where possible.
- Clear strategies to ensure trauma-informed and dignity of risk principles are embedded in practice.

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

As above.

Proposal

Proposal 5: A Senior Practitioner model should be structured to use APOs as part of the authorisation process.

An APO should:

- **have operational knowledge of how the BSP and proposed restrictive practice would be implemented,**
- **be required to meet prescribed professional standards set by the Senior Practitioner, and,**
- **be approved by the Senior Practitioner.**

Questions

Question 10: Should 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?

Of the options provided in the framework, Ability Options would support the partially delegated model for authorising specific restrictive practices including chemical and environmental restraints where they are prescribed through class or kind orders. The partially delegated model should reduce duplication and delays which would further increase administrative/ reporting burden on the provider. The use of class or kind orders allows for flexibility based on settings, cohorts and sector research to ensure appropriate safeguarding.

Risks include:

- APO is an unfunded role
- Duplication of reporting to SP and NDIS Commission when practice is unauthorised
- Reporting of authorised practices remains with Commission – will this be available to the SP to better inform reduction and elimination of practices?
- Quality of training provided to APO's by NSW government.
- Participant attendance at restrictive practice panels contributed towards self-advocacy and decision-making skill-building – this may be lost under this new framework.
- Unclear what consent will look like if we move away from a consent-based model. Will NCAT still be involved in granting specific functions?
- Knowledge imparted from DCJ Independents will be lost – how will the SP replace this? Communities of Practice for APO's?
- Auditing of APO's and interaction with NDIS Commission
- Delays in APO authorising seclusion, mechanical and physical restraint.

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

Ability Options only operates in NSW and has no experience operating under alternative models to authorisation.

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?

To ensure smaller providers or those in rural and remote areas can effectively implement the framework – capitalising on experience within the sector and minimising financial burden, APO *consultants* approved by the Senior Practitioner should be permitted.

There may be additional professional requirements as prescribed by the Senior Practitioner for those consultants acting across multiple disability service providers.

The Senior Practitioner should provide guidance to consulting APO's on how they work with external providers to gain an understanding of the operational environment in which the practice would be implemented. This may include the review of specific documentation such as floor plans, use of photos, and discussions with management and support workers alike who are responsible for implementing the practice and collecting data. The Senior Practitioner may also stipulate that behaviour support practitioners must include additional information in their plans which described how the proposed restrictive practice would be implemented in the intended operational environment.

The Senior Practitioner should monitor the performance and audit the decisions made by consulting APO's as they would APO's working for a single provider.

Ability Options is concerned that the role of the APO is not funded. Larger providers with some capacity to employ an APO should be able to provide consulting services to recover some if not all the costs associated with employing the APO internally.

Proposals

Proposal 6: The Senior Practitioner and APO should have a discretion to determine the duration of an authorisation, up to 12 months.

Proposal 7: There should be an emergency use process for restrictive practices before a BSP has been prepared and authorisation given, which should replace the interim authorisation process.

Proposal 8: The Senior Practitioner should have the power to cancel an authorisation of restrictive practices where:

- **the Senior Practitioner has determined there is no longer a need for the restrictive practice,**
- **the Senior Practitioner requests evidence to demonstrate the restrictive practice is still needed and the provider fails to provide sufficient evidence,**
- **the authorisation was obtained by materially incorrect or misleading information or by mistake,**
- **the relevant provider has contravened a condition of the authorisation, or**
- **the relevant service provider has contravened a provision of the legislation**

Questions

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

Ability Options supports the maximum 12-month duration of authorisation. We would call for the Senior Practitioner to provide further guidance around expected authorisation durations for high-risk practices such as seclusion and physical restraint.

Ability Options supports the need for an emergency use proposal for restrictive practices.

The risks of the 'emergency uses' practices under the partially delegated model do not differ greatly to the risks described in the paper regarding the current interim authorisation process (senior management can solely authorise a practice for up to 6 months with no independence and behavioural support expertise except for the requirement to have an interim BSP).

Under the existing approach to authorisation, an interim behaviour support plan is a requirement for senior management to grant interim authorisation whereas the new proposed framework places the responsibility for 'emergency authorisation' on the 'person in charge of the provider' seemingly without the requirement for an interim behaviour support plan drafted by a behaviour support practitioner. The person in charge of the provider is not independent and does not necessarily have behavioural support expertise.

Ability Options would instead call for the Senior Practitioner to hold responsibility for the emergency use authorisation of all practices as opposed to the 'person in charge of the provider' and be subject to (short but reasonable) timeframes in which they must make their decisions starting from the point at which the APO notifies them of their request and rationale for 'emergency use' authorisation.

At the point the Senior Practitioner authorises the emergency use, the implementing provider then ceases any further URP reporting to the NDIS Commision. This would reduce some of the additional compliance activities which would increase under this proposed framework: reporting to both the NDIS and Senior Practitioner at the same time for possibly lengthy periods of time whilst behaviour support plans are updated – another activity which NDIS providers are expected to cover without funding.

Ability Options calls for more clarification in relation to the use of interim behaviour support plans in the context of emergency use authorisations and the maximum duration of emergency use authorisation which should take into consideration the timeframes required to draft a comprehensive behaviour support plan/ procure funding so as not to further burden the provider with URP reporting which is in response to barriers to authorisation outside their control.

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

All the mentioned stipulation are circumstances in which the Senior Practitioner should be able to cancel authorisation:

- no longer a need for the restrictive practice
- provider fails to provide sufficient evidence that the practice is still required
- authorisation is obtained by incorrect of misleading information/ or by mistake
- the relevant provide has contravened a condition of the authorisation
- relevant service provider has contravened a provision of the legislation.

There are always varying circumstances regarding conditions or approval being met (or otherwise) – approval should not be cancelled and providers therefore left with regulatory reporting when external barriers are involved in the unmet conditions of approval. This would be particularly relevant in the respite/ MTA space, where stakeholder/ parents are often the active parties working to gain the correct evidence required for ongoing authorisation.

Proposal

Proposal 9: An affected person, the NDIS provider and any other person who has a genuine concern for the welfare of the person may seek review of an authorisation decision. The review rights would be:

- **first to the Senior Practitioner for internal review,**
- **then to the NSW Civil and Administrative Tribunal**

Questions

Question 15: Should authorisation decisions:

- **be open to internal review?**
- **be reviewable at NCAT?**

Ability Options supports the right for an affected person, the NDIS Provider and any other genuine support person to seek internal reviews of authorisation decisions.

NCAT should be a last resort when all other attempts to mediate/ address concerns have been exhausted. NCAT play a role in authorising restraints in the health setting as well as granting consenting functions to Guardians in relation to restrictive practices. The process for granting a Guardian consent functions for restrictive practices can be lengthy and result in extended periods of reporting in some circumstances – as authorisation is not valid without the appropriate legal consent. Ability Options seeks clarification regarding how NCAT would be resourced to pick up this additional reviewing function and whether the requirements for seeking consenting functions at NCAT tribunal will no longer be required under the new framework.

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?

As above. Ability Options supports the right for an affected person, the NDIS Provider and any other genuine support person to seek internal reviews of authorisation decisions which impact their freedoms.

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

Yes. Within reason and funding. Where the Service Provider of the BSP is unable to satisfy the persons concerns through review, the matter should be referred to the Senior Practitioner (or NDIS Quality and Safeguards Commissions Complaints team).

Proposals

Proposal 10: The Senior Practitioner should have powers to investigate the misuse of restrictive practices, on receipt of a complaint and on its own motion.

Proposal 11: The Senior Practitioner should have the following powers to respond to the misuse of a restrictive practice:

- **direct the provider to do / cease doing something in relation to behaviour support or the use of the restrictive practice,**
- **cancel an authorisation,**
- **refer the matter to the NDIS Commission, police or another relevant entity.**

Questions

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

SP should be able to use their investigative powers both on receipt of a complaint (referred) and on own motion based on concerns made evident through monthly reporting, APO submissions etc.

It is unclear how the Senior Practitioner and NDIS will interact.

The complaint function should stay with the NDIS – NDIS can refer to SP for investigation if the matter is complex and may require the guidance and education function of the SP.

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

Yes. Both the proposed clinical expertise and the guidance and education function of the SP makes them most suited to carrying out this piece of work.

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

Feedback and interaction should flow both ways.

If the NDIS receives a complaint regarding misuse of restrictive practices which they alone cannot resolve (i.e. requires investigation), this should be referred to the SP for investigation.

Similarly, the SP should be able to refer misuse of restrictive practices to the NDIS Quality & Safeguarding Commission and/or NSW Police, without imposing sanctions themselves.

This would ensure clear separation of roles and sensible scope of the SP's responsibilities, NDIS Quality and Safeguards Commission as enforcer, Senior Practitioner as educator.

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?

NDIS Quality & Safeguards Commission, Ageing and Disability Commission, Australian Human Rights Commission, Forensic Health.

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?

Ability Options strongly advocates for a framework which does not redirect further unfunded organisational resources to reporting activities alone. As above, we would like to see URP reporting requirements to the Commission ceased once emergency use authorisation is given by the Senior Practitioner to reduce duplication.

Ability Options seeks further clarity regarding the purposes served by reporting to both the Senior Practitioner and the NDIS Quality & Safeguards Commission, particularly reporting monthly on authorised practices to the NDIS Quality & Safeguards Commission if the reduction and elimination of practices will be the focus of the Senior Practitioner.

Proposal

Proposal 12: The Senior Practitioner should have the following functions:

- **developing and providing information, education and advice on restrictive practices to people with disability, their families and supporters, and the broader community,**
- **developing guidelines and standards, and providing expert advice, on restrictive practices and behaviour support planning.**

Question

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

Yes. The sector has seen a shift from education to compliance with very little anecdotal evidence that entrenched attitudes towards the use of restrictive practices in various community and institutional settings has changed.

We would call for the Senior Practitioner to publish case studies, statistics and data to evidence outcomes being met, benchmarking and drive continuous improvement.

Questions

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?

There is a risk that the SP's mandate is too broad: must be achievable with the resources at hand. Reduction and elimination of restrictive practices through a guidance and education function should be prioritised – it is not a function disability support providers have been able to benefit greatly from since the roll-out of the National Disability Insurance Scheme.

As above, the role of educator should sit with the SP and enforcer sit with the NDIS Commission. This will also have a positive impact on the type of conciliatory relationship providers build with the SP to continue to improve the quality of service they deliver and the quality of lives of the people they support.

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?

Not required if there is enough flexibility in the law.

Question

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?

No. We would want to see a clear separation of functions between the NDIS Commission, the Senior Practitioner and professional bodies.