**Organisation**

Independent Consultant and Former Executive Director of the Office of the Senior Practitioner (NSW FACS)

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

Yes. Practice implementation should be standard across all settings for NDIS participants.

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

It should cover all settings where people with a disability reside/ receive a service, whether these are voluntary or involuntary services. More specifically these should include Health, Justice and OOHC/VOOHC settings.

**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?**

* Understanding of the legislation and practice standards vary widely.
* A variation in 'quality' of service delivery and outcomes as a result of different frameworks.
* Capability and skill vary across service delivery settings, this more marked now since the devolution of disability and clinical services from government to the non government and private sectors.

**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.

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

* Specific physical restrictive practices eg prone restraint, pin downs.
* Punishment/punitive approaches (denial or needs, overcorrection etc).

**Question 7a: Do you agree that the framework should use the NDIS definitions of restrictive practices?**

Yes. This will assist in creating a national approach and consistent implementation and understanding of restrictive practices.

**Question 7b: Do you agree that the Senior Practitioner should have the power to issue guidelines that clarify how the definitions apply in different situations?**

Yes. The Senior Practitioner (and/ or their office) should provide advice around:

* Implementation
* Timeframes for approval and review

**Question 8: What role should the Senior Practitioner play in regulating behaviour support plans (BSP)?**

Restrictive practices form a small part of a comprehensive behaviour support plan. The Senior Practitioner, similar to the model in the ACT should have the authority to make recommendations/practice improvements as it concerns the whole plan. Based on the above approval of a plan may be time limited to allow for practice improvements to be made and monitored, e.g. a polypharmacy review is required, a psychiatrist needs to be appointed to oversee the monitoring of psychotropic medication, a more robust data collection system.

**Question 9: Is there anything else the proposed framework should do to improve the quality of behaviour support plans (BSP)?**

Approve/ not approve all components of the BSP, including practice improvements. Since moving to the NDIS there has been a scattering of skill/ capability across the sector. The proposed framework may consider training across the sector as a function of the Office of the Senior Practitioner to lift skill and practice.

**Question 10a: Should Authorised Program Officers (APOs) be empowered to authorise particular categories of restrictive practices without separate Senior Practitioner authorisation (a partially delegated model)?**

An APO could provide recommendations/ approval of all RP categories in line with practice guidelines and legislation eg seclusion/ physical restraint must be reviewed a minimum of three monthly.

The OSP (office of the Senior Practitioner) should be responsible for employing and monitoring independent APOs to ensure appropriate skill, experience and practice integrity.

**Question 10b: Should Authorised Program Officers (APOs) be empowered to provide preliminary approval of restrictive practices, with final authorisation provided in all cases by the Senior Practitioner (a two step model)?**

A two step model works well in ACT, though the independent in this case provides overall recommendations on the quality of the BSP along with the implementation of the restrictive practices.

**Question 10c: What would be the benefits and risks of the above two models for Authorised Program Officers (APOs)?**

* A two step process provides multiple opportunities for practice review including recommendations for the Office of the Senior Practitioner.
* AN APO model also reduces the time required by the OSP to review and make decisions re approval of a plan, ie all the information is provided for the OSP to consider.
* Financially, an APO model may reduce the need for a larger OSP workforce.

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

The ACT OSP model works well and provides independent practice advice.

**Question 12: Should Authorised Program Officers (APOs) be required to be employed by a single provider? Or should APOs be permitted to be consultants to a number of providers?**

APOs should be independent of providers to ensure transparent advice about implementation and practice which is free of conflict, influence or collusion.

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

Yes.

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

* Change of circumstances for a participant- ie may have been given formal diagnosis, eg dementia or a mental health diagnosis that negates a practice being deemed restrictive.
* Evidence that the plan (via frequency and severity data) is no longer meeting the needs of an individual.
* Evidence that the implementing provider is repeatedly not implementing strategies correctly or in the best interests of the participant.

**Question 15a: Should authorisation decisions be open to internal review?**

Yes.

**Question 15b: Should authorisation decisions be reviewable at NCAT?**

I would question the clinical skill and currency of practice for NCAT to do this. This could occur if the Tribunal has available a professional member who has contemporary and extensive experience delivering or overseeing positive behaviour support.

**Question 16a: Should rights to seek review be limited to the person or a person concerned for their welfare?**

No, not necessarily.

**Question 16b: Should the service provider have a right to seek review of a decision not to authorise a restrictive practice?**

In the spirit of transparency yes and clear reasons for decision should be made, though the number of reviews may be limited per BSP period.

**Question 17: Should a person have a right to request the service provider review the Behaviour Support Plan (BSP) at any time?**

As per above.

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

Both please.

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

Yes.

**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?**

The NDIA, The NDIS Quality & Safeguards Commission and in some circumstances Child Protection Services/ Police.

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

Yes, similar to the Tertiary behaviour support function and practice leader functions hosted within the Office of the Senior Practitioner / Clinical Innovation and Governance in NSW FACS.

**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?**

Need to be clear about the difference in role of the NDIS Quality and Safeguards Commission vs the Senior Practitioner- possibly a duplication of effort.

**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?**

Yes, otherwise you may have difficulty in people making timely decisions based on good practice principles but made in good faith based on the information provided.

**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?**

Good quality training in positive behaviour support, including the use of restrictive practices has been largely absent and fragmented since the commencement of the NDIS and the transfer of services from NSW Government.

A number of services were recommended to remain within government (or supported via government supported centre of excellence) by the Office of the Senior Practitioner in a report entitled the Transfer of people with complex support needs to the NDIS, these included:

1. Maintaining expertise in complex behaviour support via a tertiary service (like Statewide Behaviour Intervention Service). The training and capacity building role is particularly important and has largely been lost from the sector.
2. Providing specialist advice/ expertise in the criminal justice/ forensic space that largely intersects with behaviour support and is largely struggling in the non government sector.
3. Providing stronger leadership in the disability/ mental health space, either through enhancing training functions within the UNSW Chair established by Office of the Senior Practitioner (NSW FACS) or establishing a small number of dedicated roles within a new OSP to assist in rebuilding skill and capability in this complex area.
4. Overwhelmingly in my work I see a lack of psychiatrists in number and skill to support a disability/ psychosocial cohort. The new OSP could partner again with the Institute of Psychiatry to provide limited funding and expertise to support fellowships and increase the number of suitably qualified psychiatrists across the NSW Health system.