**Anonymous Submission**

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

Yes, OOHC should be covered for the following reasons:

* Alignment with Human Rights: Children and young people in OOHC often face heightened vulnerabilities, and restrictive practices may disproportionately impact their development and well-being. Extending the framework to OOHC would align with the UN Convention on the Rights of the Child and ensure that restrictive practices are applied only when absolutely necessary, as a last resort.
* Consistency Across Settings: Restrictive practices in OOHC are already regulated to some degree through policies like the DCJ Behaviour Support in Out-of-Home Care Policy and provider-specific behaviour support policies. However, these policies are fragmented and lack uniform legislative oversight. Including OOHC under the framework would create a consistent standard across disability, education, justice, and OOHC settings, preventing gaps in accountability.
* Overlap with Disability Services: A significant proportion of children in OOHC are NDIS participants, meaning restrictive practices in OOHC often overlap with those covered by the disability service provision setting. Including OOHC would simplify compliance by creating a single legislative framework for providers working across both settings.
* Stronger Oversight and Accountability: Introducing Senior Practitioner oversight in OOHC could reduce the overuse or misuse of restrictive practices, ensuring these are only used under appropriate conditions and as part of evidence based behaviour support plans. It would strengthen protections for children who may not have guardians or families to advocate for them.

The framework could focus initially on residential OOHC settings, where restrictive practices are most likely to be formalised and monitored. Over time, its scope could expand to foster and kinship care as practical implementation strategies are developed. A phased approach allows the system to adapt while ensuring immediate protections for children in more restrictive OOHC environments.

To avoid duplication, the framework could work alongside existing child protection regulations. For example, the Senior Practitioner could coordinate with the Office of the Children’s Guardian to ensure a consistent approach across OOHC and disability service provision settings.

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

Yes, expanding the legislation to other potential settings (such as private schools, early childhood education etc) could have the following benefits:

* Holistic Protection: Including more settings ensures that individuals with disabilities are consistently protected, regardless of where they live, learn, or work.
* Standardisation Across Sectors: A unified framework would reduce variability and ensure that restrictive practices are regulated uniformly across service environments.
* Alignment with Human Rights Principles: Expanding coverage aligns with Australia’s obligations under the UN Convention on the Rights of Persons with Disabilities (CRPD), promoting the reduction and elimination of restrictive practices in all areas of life.

If this were to be considered, the following would be recommended:

* Phased Inclusion: Suggest starting with high-priority settings (e.g., OOHC, aged care, private education) where restrictive practices are more prevalent and expanding to others after evaluating the framework’s initial effectiveness.
* Tailored Guidelines: flexible guidelines that account for the unique contexts of different settings, such as employment or early childhood education.
* Collaboration with Existing Frameworks: integrate with existing oversight mechanisms (e.g., aged care quality standards, justice system policies) to avoid duplication.
* Resource Allocation: Add additional resources for training, capacity building, and monitoring to support the inclusion of more 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?**

* Lack of Consistency: Providers who operate across both disability and aged care settings must navigate two distinct frameworks, which may include differing definitions of restrictive practices, reporting requirements, and authorisation processes. This inconsistency can lead to confusion, errors, and inefficiencies in implementation, potentially affecting the quality of care for individuals receiving services.
* Inequities in Rights Protections: The disability framework prioritises the reduction and elimination of restrictive practices through behaviour support plans, while the aged care framework often focuses on managing risks without the same explicit emphasis on elimination. As a result, individuals in aged care may not benefit from the same level of rights protections and oversight as those in disability services, despite being equally vulnerable to the misuse of restrictive practices.
* Disparities in Oversight and Accountability: The introduction of a Senior Practitioner model in the disability framework provides robust oversight, ensuring restrictive practices are authorised and monitored according to clear principles. In contrast, aged care relies primarily on local management and audits by the Aged Care Quality and Safety Commission, which may not offer the same level of independent scrutiny.
* Fragmentation of Care: Individuals transitioning between disability services and aged care (e.g., due to aging or loss of NDIS eligibility) may experience significant differences in how restrictive practices are managed. This lack of alignment can result in reduced protections and support, creating unnecessary stress for individuals and their families.
* Increased Administrative Burden: Providers managing compliance with two frameworks face increased administrative demands, particularly in maintaining separate reporting and training systems. This burden may disproportionately affect smaller providers with limited resources.

**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, I support legislation requiring that restrictive practices on NDIS participants in the disability service provision, health, education, and justice settings be governed by the principles recommended by DRC Recommendation 6.35(b). This approach upholds human rights, ensures accountability, and provides a pathway for reducing and eventually eliminating restrictive practices.

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

The following principles could be considered to strengthen the framework for restrictive practices:

* Cultural Competency and Inclusivity: Restrictive practices must be culturally sensitive and consider the individual's background, including Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, and others. Behaviour Support Plans should incorporate strategies that reflect cultural values and practices, and consultations should involve culturally appropriate representatives where relevant.
* Trauma-Informed Approach: Ensure that decisions about restrictive practices consider the potential for re-traumatisation in individuals who may have experienced trauma in their past. Behaviour support practitioners should be trained in trauma-informed care to minimise harm.
* Periodic Review and Reduction Targets: Include specific provisions for periodic review of restrictive practices to assess their necessity, effectiveness, and progress toward reduction and elimination goals. Require clear, measurable reduction targets in Behaviour Support Plans.
* Collaboration and Family/Guardian Involvement: Emphasise meaningful collaboration with families, guardians, and other informal supports in the development and review of BSPs. Guardians and families should have access to training or resources to understand restrictive practices and advocate effectively for the individual.
* Focus on Prevention: The framework should include a stronger focus on preventative measures to address behaviours of concern, such as early intervention, access to therapeutic supports, and environmental modifications.
* Rights-Based Decision-Making: Include explicit reference to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) to ensure decisions align with international human rights standards. Empower individuals with disabilities to participate in decision-making through supported decision-making approaches.

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

Yes, a legislative framework should prohibit certain restrictive practices, particularly those that are inherently harmful, dehumanising, or pose significant risks to the health, safety, or dignity of individuals. Specific practices and the settings in which they should be prohibited include the following:

* Dangerous Physical Restraints: Practices that restrict breathing or risk serious physical harm, such as prone restraints, supine restraints, or any form of restraint that involves compressing the chest, neck, or abdomen. Should be prohibited across all settings, including disability services, health, education, and justice, as the risks outweigh any potential benefits.
* Seclusion Beyond Short-Term Emergencies: The long-term or indefinite confinement of individuals in isolation without active monitoring or engagement. Prohibit in disability services, education, and health settings, where isolation can exacerbate distress and trauma. Temporary seclusion may be permitted in justice settings under strictly regulated conditions with oversight.
* Chemical Restraint for Non-Therapeutic Purposes: The use of medications primarily to control behaviour rather than for therapeutic treatment. Should be prohibited in all settings unless explicitly prescribed for therapeutic purposes and reviewed regularly by a medical professional.
* Mechanical Restraints: Restraints like harnesses or belts that restrict movement, unless prescribed for therapeutic or medical reasons (e.g., preventing falls in medical settings). Should be prohibited in disability services, education, and health settings unless justified by a medical professional and part of a broader therapeutic plan.
* Prolonged Environmental Restraint: Practices that restrict an individual's freedom of movement in a way that is disproportionate to the behaviour being managed (e.g., locking individuals in their homes or rooms for extended periods). Prohibit in disability and education settings, where such restrictions are often unnecessary and harmful. Regulate carefully in justice and health settings to ensure safety.
* Use of Restraints as Punishment: Any form of restrictive practice used as a disciplinary or punitive measure. Prohibit in all settings as such practices violate the principles of dignity and respect for individuals with disabilities.

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

Yes, the framework should use the NDIS definitions of restrictive practices for the following reasons:

* Consistency Across Jurisdictions: Adopting the NDIS definitions ensures alignment with national standards, promoting consistency across states and territories. Providers working across multiple jurisdictions will benefit from a unified understanding of restrictive practices, reducing confusion and administrative burden.
* Established and Comprehensive Definitions: The NDIS definitions comprehensively cover the five key types of restrictive practices. These definitions are well-established and familiar to service providers, behaviour support practitioners, and stakeholders, reducing the need for retraining or reinterpretation.
* Supports a Rights-Based Approach: The NDIS definitions focus on practices that restrict rights or freedom of movement, aligning with the broader goals of safeguarding individual rights and promoting person-centred care. They exclude practices that are not intended to influence behaviour, such as therapeutic interventions, which ensures the focus remains on addressing behaviours of concern.
* National Policy Alignment: Aligning with the NDIS definitions supports the overarching goals of the National Disability Insurance Scheme Quality and Safeguarding Framework, which aims to reduce and eliminate restrictive practices while protecting individuals' rights.

If the NDIS definitions are adopted, guidelines issued by the Senior Practitioner should emphasise practical examples and sector-specific clarifications to ensure smooth implementation. The framework should incorporate provisions for regular reviews of the definitions and guidelines to ensure they remain relevant and responsive to evolving best 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 should have the power to issue guidelines that clarify how the definitions of restrictive practices apply in different situations. This is important for the following reasons:

* Clarity and Practical Application: Definitions alone may not always address the nuances and complexities of real-world scenarios. Guidelines from the Senior Practitioner can provide practical examples, case studies, and detailed explanations, making it easier for providers and practitioners to interpret and apply the definitions appropriately.
* Flexibility Across Diverse Settings: Restrictive practices occur in a wide variety of contexts, including disability services, health, education, and justice. These settings often have different operational needs and challenges. Senior Practitioner guidelines can tailor the application of definitions to these settings, ensuring the framework is relevant and effective while respecting the unique demands of each sector.
* Supporting Best Practices: The guidelines can address common misconceptions or areas of confusion, such as differentiating between restrictive practices and reasonable adjustments or therapeutic interventions. By offering clear guidance, the Senior Practitioner can help providers adopt evidence-based and person-centred approaches, reducing the reliance on restrictive practices.
* Promoting National Consistency: Although the NDIS definitions provide a national standard, their interpretation may vary between jurisdictions or settings. Guidelines from the Senior Practitioner can ensure consistent application within NSW, contributing to national consistency while respecting local needs.
* Addressing Emerging Issues: The disability sector evolves as new technologies, therapeutic practices, and medications emerge. The ability to issue guidelines gives the Senior Practitioner flexibility to address these developments without requiring frequent legislative amendments.
* Enhancing Compliance and Accountability: Guidelines provide providers with clear expectations, reducing unintentional non-compliance. Additionally, they offer a benchmark against which the use of restrictive practices can be audited, supporting the Senior Practitioner’s oversight and enforcement role.

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

* Setting Standards and Guidelines: Establish minimum requirements for the development, content, and quality of BSPs. These standards should ensure that BSPs include evidence-based, person-centred strategies, address the root causes of behaviours of concern, prioritise alternatives to restrictive practices, align with the principles recommended by the Disability Royal Commission (e.g., last resort, least restrictive, proportionate, and time-limited).
* Reviewing and Approving BSPs: Oversee the review and approval of BSPs that include restrictive practices, either directly or through a delegated process (e.g., Authorised Program Officers).
* Enhancing the Quality of BSPs: Implement mechanisms to improve the overall quality of BSPs, such as requiring additional information, such as cultural considerations, mandating that BSPs include progress reviews and outcomes of previous strategies to reduce restrictive practices.
* Regulating Behaviour Support Practitioners: Set qualifications and training requirements for practitioners who develop BSPs, ensuring they possess the necessary skills and knowledge.
* Monitoring Compliance: Establish mechanisms to monitor compliance with BSP requirements and the use of restrictive practices.
* Supporting Education and Capacity Building: Provide education, resources, and support to behaviour support practitioners, providers, and other stakeholders to improve BSP quality.
* Ensuring Independent Review: Facilitate independent review of BSPs and decisions related to restrictive practices.

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

* Mandate Individualised and Person-Centred Approaches: Require that all BSPs explicitly reflect the individual's needs, preferences, communication style, cultural background, and environmental factors.
* Develop a Centralised Repository for Best Practices: Establish a centralised repository of best practices, case studies, and templates for developing high-quality BSPs.
* Ensure Holistic Functional Behaviour Assessments (FBAs): Require that all BSPs be based on comprehensive FBAs that identify the underlying causes of behaviours of concern, Assess environmental, psychological, and social factors contributing to the behaviour, Include input from multidisciplinary teams where necessary.
* Strengthen Consultation Requirements:
* Incorporate Cultural and Social Considerations: Ensure BSPs explicitly address cultural, linguistic, and social factors.
* Set Clear, Measurable Goals: Require BSPs to include clear, measurable objectives for reducing and eventually eliminating restrictive practices.
* Enhance Practitioner Training and Qualifications: Require behaviour support practitioners to complete specialised training in evidence-based interventions, person-centred planning, and trauma-informed care. Provide ongoing professional development opportunities.

**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)?**

Yes, but only for low-risk restrictive practices, such as environmental restraints and certain forms of chemical restraint used for therapeutic purposes (e.g., anti-anxiety medications prescribed to address behaviour-related distress). High-risk practices (e.g., seclusion, physical restraints, mechanical restraints) should require the direct involvement of the Senior Practitioner.

**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)?**

Yes, a two-step model could work effectively for balancing timeliness and oversight.

Preliminary Approval by APOs: APOs could ensure restrictive practices are implemented promptly in urgent situations while adhering to the principles outlined in legislation.

Final Authorisation by the Senior Practitioner: Provides an added layer of scrutiny and ensures practices align with best practices and ethical standards.

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

Partially Delegated Model (APOs Empowered to Authorise Low-Risk Practices)

Benefits:

* Timeliness: Low-risk practices can be authorised quickly, reducing delays in situations where immediate action is needed.
* Operational Efficiency: Reduces the workload of the Senior Practitioner, allowing them to focus on high-risk cases.
* Local Knowledge: APOs are familiar with the operational context and can make more practical, situation-specific decisions.

Risks:

* Conflict of Interest: APOs employed or retained by the provider may face pressure to approve practices that benefit the provider’s operations.
* Inconsistent Standards: Without clear oversight, variations in APOs' decisions across providers could emerge.
* Lack of Oversight for High-Risk Practices: There is a risk of misclassification or inappropriate authorisation if guidelines are unclear.

Two-Step Model (Preliminary Approval by APOs, Final Authorisation by Senior Practitioner)

Benefits:

* Increased Safeguards: Final authorisation by the Senior Practitioner adds an independent review layer, reducing the risk of misuse or inappropriate approvals.
* Better Accountability: The Senior Practitioner remains the ultimate authority, ensuring compliance with legislative principles.
* Balanced Approach: Combines the operational efficiency of APOs with the oversight of a centralised authority.

Risks:

* Delays: The two-step process might introduce delays in authorisation, particularly in high-risk cases where swift action is required.
* Administrative Burden: Increased workload for both APOs and the Senior Practitioner’s office, potentially requiring more resources.
* Potential Duplication: The process could become redundant if APOs and the Senior Practitioner are required to review the same information.

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

Risk-Tiered Model: Categorise restrictive practices into tiers based on risk:

* Tier 1 (Low Risk): Authorised by APOs with notification to the Senior Practitioner.
* Tier 2 (Moderate Risk): Joint approval by APOs and Senior Practitioner.
* Tier 3 (High Risk): Direct approval by the Senior Practitioner only.

Benefit: Ensures oversight is proportionate to risk while maintaining efficiency.

Risk: Requires clear definitions of risk tiers and may be complex to implement.

**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?**

I believe the challenges for both of these options are significant.

Option 1: APOs Employed by a Single Provider

Advantages:

* Stronger Operational Knowledge: APOs develop a deeper understanding of the provider’s unique operational environment, leading to more contextually informed decisions.
* Clearer Accountability: Direct employment ensures a single point of responsibility for the APO’s actions, reducing risks of divided loyalties or external conflicts of interest.
* Consistency: Continuity in decision-making and follow-through on Behaviour Support Plans (BSPs) is easier to achieve.

Challenges:

* Resource Limitations: Smaller or regional providers may not have the capacity to employ full-time APOs, leading to gaps in service delivery.
* Workforce Shortages: Recruiting sufficient qualified APOs might be challenging, especially in less accessible areas.

Option 2: APOs as Consultants to Multiple Providers

Advantages:

* Flexibility: Enables smaller or regional providers to access APO expertise without needing a full-time position.
* Resource Efficiency: Highly skilled APOs can work across multiple providers, maximizing their impact and reducing duplication of expertise.
* Capacity Building: Facilitates a wider spread of knowledge and practices across different providers.

Challenges:

* Conflict of Interest: Managing multiple providers can lead to perceived or actual conflicts, compromising impartiality.
* Operational Disconnect: APOs may lack the depth of understanding of each provider’s systems and practices.
* Consistency Issues: Variability in decisions and follow-through might arise due to the fragmented nature of the role.

Therefore I suggest a combined model:

* Single-Provider APOs for Complex or High-Risk Cases: Larger providers or those dealing with high-risk cases (e.g., seclusion, mechanical restraints) should employ APOs full-time to ensure close oversight and contextually informed decisions.
* Consulting APOs for Smaller Providers: Allow APOs to consult for multiple smaller providers, ensuring access to expertise while maintaining affordability. Safeguards like conflict-of-interest policies, oversight by the Senior Practitioner, and strict reporting requirements would mitigate risks.

Benefits of a Hybrid Model:

* Balances flexibility with accountability.
* Addresses workforce shortages while ensuring high-quality authorisation and oversight.
* Ensures smaller providers are not disadvantaged by resource limitations.

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

I support this proposal because a maximum 12-month duration aligns with NDIS requirements for Behaviour Support Plans (BSPs) and ensures regular review of restrictive practices. The requirement for providers to submit updated BSPs and evidence of efforts to reduce restrictive practices strengthens accountability and encourages continuous improvement.

I support replacing the interim authorisation process with an emergency use process under strict safeguards. This is important because:

* It allows timely responses to imminent risks of harm while ensuring the use of restrictive practices remains a last resort.
* Requiring notification to the Senior Practitioner and detailed reporting of emergency uses promotes transparency and oversight.
* The emphasis on transitioning to a formal BSP and authorisation as soon as practicable ensures temporary measures do not become routine.

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

The proposed grounds for cancellation are comprehensive, but the following additional grounds could further enhance the framework:

* Non-compliance with Reporting Requirements: If the provider fails to meet mandatory reporting obligations (e.g., monthly reports on restrictive practice use or emergency applications), the Senior Practitioner should have the power to cancel authorisation.
* Breach of Consultation Obligations: If the provider fails to adequately consult with the person subject to the restrictive practice, their family, or guardian during the development or implementation of the BSP.
* Repeated or Systemic Misuse of Restrictive Practices: If a provider demonstrates repeated misuse of restrictive practices or systemic non-compliance with legislative principles (e.g., failure to use restrictive practices as a last resort or for the shortest time possible).
* Significant Changes in Circumstances: If there are significant changes in the individual's condition, environment, or support needs that render the restrictive practice inappropriate or unnecessary.

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

Yes, authorisation decisions should be open to internal review by the Senior Practitioner. An internal review provides a quick and cost-effective mechanism to address potential errors or disputes without requiring immediate escalation to external bodies. It ensures accountability within the Senior Practitioner’s office and provides an opportunity for reflection and correction of decisions.

Safeguards: The internal review process should be time-bound, transparent, and include clear documentation of the basis for decisions.

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

Yes, decisions should be reviewable at the NSW Civil and Administrative Tribunal (NCAT). An external review mechanism ensures impartiality and provides a pathway for individuals or providers to challenge decisions they believe are unfair or inconsistent with the law. NCAT has the expertise to adjudicate complex matters involving restrictive practices and individual rights.

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

No, rights to seek review should not be strictly limited to the affected person or those concerned for their welfare.

Expanded Right: Include advocates, disability advocates, or appointed representatives with a legitimate interest in the individual's welfare.

Rationale: Some individuals subjected to restrictive practices may lack the capacity or means to seek review independently. Broadening review rights ensures better protection of vulnerable individuals and aligns with principles of accessibility and equity.

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

Yes, service providers should have the right to seek review of a decision not to authorise a restrictive practice.

Rationale: Service providers often operate in high-risk environments and must ensure the safety of both individuals and staff. If a decision not to authorise a restrictive practice jeopardises safety, a review mechanism is essential.

Ensures the decision-making process is thorough and accounts for operational realities.

Safeguards: The provider’s right to review should include documentation demonstrating why the restrictive practice is deemed necessary and evidence supporting their position.

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

Yes, individuals and their representatives should have the right to request a review of the BSP at any time.

Rationale: BSPs should evolve to reflect changes in the individual’s circumstances, progress, or needs. Allowing ongoing review promotes adaptability and ensures the BSP remains appropriate and effective.

Empowers individuals and their families, fostering person-centred care and alignment with their rights.

Safeguards: Set reasonable timeframes for the provider to respond to requests for BSP reviews. Ensure consultation with the individual, their family, and the APO during the review process.

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

Yes, the Senior Practitioner should have complaints handling and investigation functions both on receipt of a complaint and on its own motion.

Rationale:

* Complaint-Driven Investigations: Empower individuals, families, and advocates to raise concerns about the misuse of restrictive practices, ensuring accountability.
* Own-Motion Investigations: Address situations where vulnerable individuals may be unable to file complaints (e.g., due to cognitive impairments or fear of reprisal). This also allows the Senior Practitioner to proactively address systemic issues or patterns of misuse.

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

Yes, the Senior Practitioner should have the proposed powers to:

* Direct the provider to act or cease actions: Ensures immediate rectification of harmful practices or non-compliance.
* Cancel an authorisation: Provides a critical safeguard to prevent further harm where practices are unnecessary, misused, or improperly authorised.
* Refer matters to the NDIS Commission, police, or other entities: Aligns with the need for multidisciplinary oversight and ensures that severe or criminal misuse of restrictive practices is addressed appropriately.
* Additional Suggestion: Consider adding the power to mandate remedial training for providers found in breach, promoting compliance and education.

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

Interaction with the NDIS complaints framework should be collaborative, complementary, and clearly defined:

* Clear Roles and Responsibilities: Define the scope of the Senior Practitioner’s authority versus the NDIS Commission to avoid duplication or confusion. For example:
  + The Senior Practitioner should handle authorisation-related matters and systemic misuse of restrictive practices.
  + The NDIS Commission should address broader service provider compliance and participant rights under NDIS standards.
* Information Sharing Agreements: Establish protocols for timely sharing of complaints and investigation findings between the Senior Practitioner and the NDIS Commission.
* Joint Investigations: Allow for coordinated investigations in cases involving overlap, such as systemic misuse by registered NDIS providers.

**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 Commission: When complaints or findings involve registered NDIS providers.

For regulatory oversight or enforcement actions.

* Police or Law Enforcement: When misuse of restrictive practices constitutes criminal behaviour (e.g., abuse, neglect).
* Other Regulatory Entities (e.g., Ombudsman, NSW Health): Where issues intersect with other oversight bodies (e.g., education, justice, health sectors).
* Courts and Tribunals: When required for legal proceedings or reviews.
* Individuals and Families: To provide transparency and updates on investigation outcomes, respecting privacy and confidentiality.

Circumstances for Information Sharing:

* Information sharing should align with privacy laws and be limited to cases where it:
* Protects the welfare and rights of individuals subjected to restrictive practices.
* Prevents further misuse or harm.
* Facilitates accountability and systemic improvement.

**Question 22a: 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?**

The proposed means, which include regular reporting, audits of Authorised Program Officers (APOs), and notifications of authorisations, are strong foundational mechanisms. However, some additional measures could enhance visibility:

a. Additional Reporting Requirements:

* Justifications for Restrictive Practices: Providers should submit not just the fact of use but detailed explanations, including efforts to use less restrictive alternatives.
* Outcomes Monitoring: Require providers to report progress in reducing restrictive practices, including measurable indicators of the individual’s skill development or behaviour improvements.
* Stakeholder Input: Include summaries of consultations with individuals, families, and guardians on the appropriateness of practices and their impact.

b. Data Collection on Systemic Trends:

* Require aggregated, anonymised data on the use of restrictive practices to identify systemic trends (e.g., frequency, types of practices, and demographics affected). This helps the Senior Practitioner address broader patterns of concern.

c. Emergency Use Notifications:

* Implement a real-time notification system for emergency uses of restrictive practices to ensure timely oversight of high-risk cases.

**Question 22b: How can reporting burden to the Senior Practitioner and the NDIS Commission be minimised?**

Streamlined Reporting Systems:

* Unified Reporting Platforms: Develop a shared online platform for providers to report directly to both the Senior Practitioner and the NDIS Commission, reducing duplication.
* Automated Data Entry: Allow providers to upload BSP data directly from their systems, with automated extraction of relevant fields for reporting.

Tiered Reporting Requirements:

* Risk-Based Reporting: Adjust reporting frequency based on provider performance and compliance history. High performing providers might report less frequently, while those under scrutiny provide more detailed reports.
* Simplified Reports for Low-Risk Practices: For less restrictive practices (e.g., environmental restraints), require only basic summaries unless issues arise.

Collaborative Audits:

* Joint Audits with the NDIS Commission: Where possible, coordinate audits to avoid multiple inspections of the same provider.

Standardised Templates and Guidelines:

* Provide standardised reporting templates to ensure consistency and reduce time spent preparing reports. Include examples to clarify requirements.

Encourage Technology Adoption:

* Encourage providers to use digital behaviour tracking and reporting tools that integrate with the Senior Practitioner’s system. This reduces manual reporting effort and ensures timely, accurate data submission.

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

Yes, I agree that the Senior Practitioner should have the proposed education and guidance functions. These responsibilities are essential for ensuring the safe, ethical, and person-centred use of restrictive practices while promoting their reduction and elimination over time.

Reasons for Agreement:

* Empowerment Through Education: Providing information and advice to people with disability, their families, and supporters empowers them to understand their rights, the purpose of restrictive practices, and how to advocate for alternatives. Education helps reduce misuse and reliance on restrictive practices by fostering a culture of positive behaviour support.
* Building Capacity in the Sector: Guidelines and expert advice from the Senior Practitioner equip providers with the tools and knowledge necessary to implement high-quality Behaviour Support Plans (BSPs) and alternative strategies to restrictive practices. Promotes consistent application of best practices across the sector.
* Alignment with Legislative Goals: These functions align with the overarching goal of reducing and, where possible, eliminating restrictive practices, as outlined in the Disability Royal Commission recommendations.
* Community Awareness: Engaging the broader community through education initiatives reduces stigma and misunderstanding surrounding disability and restrictive practices, fostering a more inclusive society.
* Adaptability and Continuous Improvement: Developing and updating guidelines ensures practices remain relevant and effective in light of evolving research, technologies, and individual needs.

Additional Recommendations:

* Accessible Materials:
  + Ensure information and guidelines are available in accessible formats (e.g., Easy Read, audio, translated materials) to reach diverse audiences.
* Collaboration with Stakeholders:
  + Engage with people with disability, families, advocates, and providers when developing education materials and guidelines to ensure relevance and practicality.
* Ongoing Professional Development:
  + Facilitate regular training sessions for Authorised Program Officers (APOs), behaviour support practitioners, and providers on the latest standards and strategies for reducing restrictive practices.

**Question 24a: 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?**

Yes, the Senior Practitioner should have the power to impose sanctions for the misuse of restrictive practices.

Rationale:

* Targeted Accountability: While existing sanctions under NDIS legislation provide a foundation, the Senior Practitioner is uniquely positioned to address misuse specific to authorisation and oversight processes within the NSW framework.
* Timely Responses: The Senior Practitioner can act more swiftly to address breaches than external bodies like the NDIS Commission, ensuring immediate resolution and protecting individuals.
* Complementary to Existing Systems: The Senior Practitioner’s sanctions would focus on breaches of authorisation conditions, misuse during emergency use, or failure to comply with state-level guidance, complementing broader NDIS enforcement measures.

**Question 24b: How should the interaction between sanctions provided for under NDIS legislation and the proposed framework be managed?**

Collaboration and Clarity:

* Clear Jurisdictional Boundaries: Define the respective roles of the NDIS Commission and the Senior Practitioner. For example:
* The NDIS Commission handles systemic provider compliance and severe misconduct.
* The Senior Practitioner addresses breaches related to NSW authorisation and oversight.
* Information Sharing: Establish protocols to ensure both entities are aware of investigations, sanctions, and outcomes.
* Joint Investigations: For complex or overlapping cases, consider coordinated investigations between the Senior Practitioner and the NDIS Commission.
* Avoid Duplication: Develop processes to ensure that sanctions imposed by one entity do not unnecessarily replicate penalties imposed by the other.

**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, the framework should include legislated immunity for individuals acting in good faith and in compliance with an authorisation.

Rationale:

* Encourages Compliance: Immunity provides assurance to providers and staff that they will not face undue legal risk when following lawful authorisations and BSPs.
* Good Faith Protection: Protects staff who act in accordance with authorisations and approved BSPs but face unforeseen outcomes despite their adherence to the framework.
* Prevents Defensive Practices: Reduces the likelihood of providers avoiding necessary actions out of fear of legal repercussions.

**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?**

1. Promoting Research and Innovation

* Function: Support and promote research into alternatives to restrictive practices and effective behaviour support strategies.
* Rationale: Encourages evidence-based practices that reduce reliance on restrictive practices and fosters innovation in person-centred care.
* Implementation:
* Partner with academic institutions, service providers, and advocacy organisations.
* Provide grants or funding for research initiatives.

2. Monitoring Systemic Trends and Reporting

* Function: Develop an annual public report summarising trends, systemic issues, and progress in reducing restrictive practices across the sector.
* Rationale: Increases transparency, promotes accountability, and helps identify areas for improvement or additional focus.
* Implementation:
  + Analyse data collected from providers, audits, and investigations.
  + Highlight successful strategies and areas needing intervention.

3. Strengthening Collaboration Across Sectors

* Function: Act as a liaison between the disability, health, education, and justice sectors to ensure consistent application of restrictive practice principles across different settings.
* Rationale: Ensures that best practices are shared and adapted to different contexts, promoting consistency and safeguarding individuals’ rights.
* Implementation:
  + Convene interagency forums or working groups.
  + Develop cross-sector guidelines for restrictive practices.

4. Advising on Workforce Development

* Function: Advise on the training, qualifications, and workforce development needs of behaviour support practitioners and Authorised Program Officers (APOs).
* Rationale: Ensures a skilled and consistent workforce capable of implementing the framework effectively.
* Implementation:
  + Develop competency standards in collaboration with training bodies.
  + Identify gaps in workforce capacity and recommend solutions.

5. Empowering Advocacy and Peer Support

* Function: Facilitate the development of advocacy and peer support networks for individuals subjected to restrictive practices and their families.
* Rationale: Ensures that individuals and families have access to resources and support to advocate for alternatives and informed decision-making.
* Implementation:
  + Partner with advocacy organisations to provide training and resources.
  + Create forums for sharing lived experiences and best practices.

Additional Requirements for Providers in the Disability Service Provision Setting

* Continuous Quality Improvement:
  + Require providers to implement a quality improvement plan focused on reducing restrictive practices and enhancing behaviour support.
  + Mandate periodic reporting on progress toward measurable goals.
* Mandatory Stakeholder Engagement:
  + Providers should engage individuals, families, and advocates in the development, review, and evaluation of
  + Behaviour Support Plans (BSPs).
  + Document all consultations and include a summary in BSPs submitted for authorisation.
* Cultural Competency Requirements:
  + Require providers to demonstrate cultural competency, particularly for Aboriginal and Torres Strait Islander individuals and culturally and linguistically diverse (CALD) communities.
  + Include specific training modules for staff on cultural considerations in behaviour support.