**Anonymous Submission**

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

Legislation should be restricted to NDIS services/settings.

Unintended consequences are a real risk of the proposal. For example, children/adolescents/adults living in out of home care settings typically have limited access to friends/family and likely cultural practices (prohibited practices). In the case of children and adolescents this has very likely arisen in the context of violent behaviour that is no longer tolerable/manageable by the family and may have resulted in serious injury or property damage. The person may want to visit home, but that may no longer be feasible.

It is bizarre that a commonly used practice, response cost, is listed as a prohibited practice. This presents a risk to those who reasonably and appropriately use this practice to positively influence behaviour or to keep people safe who could be penalised.

Response cost underpins a commonly used positive practice of First/then, in which the person with disability needs to undertake a prescribed task before they get a reward/preferred item/activity. For example- the child eats their meal before they get access to computer.

The list of prohibited practices requires review.

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

No definitely not health. It is unrealistic for a senior practitioner to have governance responsibility in other settings such as health, including private health settings. the senior prac (NDIS) would not have sufficient understanding of the contexts in other settings such as health or education. There cant be an approval mechanism of the sort proposed without related governance responsibilities.

**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?**

There are major risks arising from the proposal as outlined above. It is worth common ground being established with an agreement on principles underpinning limitation on restrictive practices.

However, there currently exists substantial misunderstanding of the role of medication and the conflation with chemical restraint (restrictive practice). This may inadvertently impact appropriate/reasonable prescribing that could benefit the person with disability. It isn’t understood that for many people with a disability, who have difficulties expressing their needs even with augmented/alternative communication supports, behaviour is the main means of communication. This is the case in mental health conditions such as anxiety.

**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)?**

No should not be legislated for health. However the principles should be accepted and embedded in policy.

Such a policy should ten be supported by appropriate health resources, both financial and skills to properly support people with disability in the health sector using a wholistic approach and positive practices, especially communication supports.

Its a major concern of mine that there has been a serious and dramatic diminishing of skills and availability of specialist support practitioners. Previously they had qualifications, such as psychology, further training and experience supporting by appropriate clinical governance. This has been lost to the system along with extreme fragmentation of the disability sector and a disengagement of the disability sector from others such as health and education.

These changes are responsible for perpetuating serious and violent behaviour due to limited quality of BSPs, absence of implementation supports/training, failure to consider the contexts and capacity of family/schools etc to implement recommended strategies, limited supply of appropriately trained professionals, the pressures of business models that NDIS has driven that favours less complex cases over more complex cases and funding cut backs for the most complex clients.

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

The principles of safety isn’t included. For example, it may be paramount to keep the person/others safe, eg risk of running onto road, physical attacks of car driver, hitting baby sibling.

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

The current prohibited list is contentious, esp with respect to

* Specific restraint c) pin down- sometimes restraining arms is necessary to prevent harm to the person or others
* Punitive c) denying access (might not be safe to do this) e) practices to deny culture (may not be safe, eg attending church) f) response cost (proportionate response cost is a mainstay of most behaviour management/regular parenting)

Some practices ought to be prohibited- ie those that present known risk to life/serious harm, eg prone position, interfering with respiration.

Legislation should restrict a narrow range of high-risk practices only.

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

Framework legislation should be restricted to NDIS settings.

Senior Prac doesn’t have and can’t be expected to have authority in other settings such as health. They should not have power to issues guidelines for other settings.

Any action in relation to chemical restraint that could overrule treating doctor must be discussed with them and potentially seek expert additional medical opinion. No other profession has the skill set to make decisions in relation to medication use.

A driving factor in ongoing use of restrictive practices is the breakdown in disability service sector that comprises fewer experienced practitioners, largely absent clinical governance and meaningful interagency partnerships, high turnover of staff/services and funding restrictions that compromise service provision among others.

These issues require urgent attention as they typically precede use of restrictive practices.

My practice is solely with children and adolescents with disabilities. It’s well known that they have high rates of comorbid mental health and physical health conditions and typically underlying biological differences that are complicating the picture.

**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?**

No.

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

THE SP ought to ensure that BSP have appropriate qualifications, training and work in appropriate models of care that includes sustained engagement beyond initial assessment. They should be mandating quality BSPS as well as appropriate implementation plans and ensure these are funded and delivered.

**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)?**

No. it is a direct conflict of interest that weakens oversight of restrictive practices for APO model to be implemented in current NDIS business model.

**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)?**

No.

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

Conflict of interest.

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

Senior practitioner with adequate resourcing.

**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?**

No.

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

Approving RP for 12 months is reasonable if there is sustained NDIS services including behaviour support practitioner and other therapists involved. Far too often i see fragmentation of NDIS services to a catastrophic level. NDIS system should address this as a priority. One strategy could be referral to complex pathway for all FP approvals other than those where there are active/sustained services and rapid resolution of the challenging behaviours.

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

Yes, where the RP are being misused by NDIS provider/person harmed.

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

Yes.

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

Yes.

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

No, health or education provider could be well positioned to act where there are concerns to make a notification.

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

Yes.

**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, within constraints previously described. Requires public reporting annually- deidentified. Where medical/chemical restraint involved- must involve original medical prescriber and potentially expert medical opinion.

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

Yes within NDIS services.

**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?**

Public reporting needed for restrictive practices decisions/reviews/complaints (deidentified).

**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?**

Currently there exists other legislation eg if abuse/assault of person occurs. Sanctions including withdrawal of approval as BSP should be available.