Australian College of Nurse Practitioners response to:

NSW Government – Department of Communities and Justice

Restrictive Practices Legislative Framework

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Supporting Nurse Practitioners through advocacy resources, networking and professional development

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NSW Government Department of Communities and Justice
Restrictive Practices Legislative Framework

By email: policy@dcj.nsw.gov.au

To the Department of Communities and Justice,

Thank you for the opportunity to provide feedback on a legislated framework for regulating the use of restrictive practices on people with disability in New South Wales,

The Australian College of Nurse Practitioners (ACNP) is the leading national body representing nurse practitioners. It drives the advancement of nursing practice and strengthens consumer access to healthcare services. Nurse practitioners are uniquely equipped to address unmet healthcare needs within communities and expand access to safe high-quality care, especially for underserved populations including those with an intellectual and physical disabilities, autistic people and people with psychosocial disability.
The ACNP acknowledges and supports the findings of the Disability Royal Commission (DRC), particularly regarding their recommendations for stronger legal frameworks to regulate restrictive practices, immediate action to prohibit specific practices, improved data collection, and the establishment of clear performance indicators.

Our responses to the consultation questions are as follows:

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

Yes, the ACNP advocates for the legislative framework to include the out-of-home care setting.
The use of restrictive practices in aged care homes, out of home settings and the Justice system must be formally authorised and should adhere to the principle of employing the least restrictive practice necessary to firstly avoid harms from behaviors which place the person or staff and risk vs the potential risk of the restraint itself being harmful. A stepped approach should be implemented, again taking into account the individual's behaviors, as well as the risk of self-harm or harm to others. Each intervention must be proportionate to the identified risks and tailored to the specific needs of the client.

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

The proposed legislative framework should comprehensively address the use of restrictive practices across a range of settings, including in schools, during transport, at home and out of home, in all disability services and support work, as well as in prisons (justice system) and hospitals.

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? Proposals

The utilisation of different frameworks for the authorisation of restrictive practices in both the aged care and disability settings raises several issues and challenges. The lack of a unified framework can lead to inconsistencies in the application and oversight of restrictive practices, potentially resulting in disparities in the protection of individuals' rights and well-being across both sectors. This can make it difficult for service providers to navigate the differences in regulations, leading to confusion, inefficiency, and potential breaches in standards.

One significant concern is the increasing number of National Disability Insurance Scheme (NDIS) participants who will require aged care in the near future. As the population ages, more individuals with disabilities will also need aged care services. The ACNP is concerned that the distinct regulatory frameworks governing restrictive practices in disability services and aged care may create challenges in meeting the complex needs of these individuals. Many people will require a hybrid of both aged care and disability care services, and legislation must be designed to adequately address this intersection to prevent fragmentation of care and potential gaps in the inadvertent use of restrictive practices. Furthermore, if authorised restrictive interventions are used on a person in these settings, they must be documented, monitored, and reported through a formalised and robust system, to prevent harm to clients, while also adequately protecting staff who may be at risk from dangerous behaviors of concern.

Proposal:

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, the ACNP supports this legislation in line with DRC recommendation 6.35(b) in all settings.
However, it must be noted that not all individuals in the NSW community diagnosed with a disability are participants in the NDIS. Restrictive practice legislation in the disability sector in NSW must be inclusive of all persons with a disability, based on their diagnosis, not solely on their registration with a funding scheme such as the NDIS. For example, attention deficit hyperactivity disorder (ADHD) is not on the NDIS list of approved disabilities for funding and, therefore, individuals with ADHD are ineligible to participate in the scheme, yet they can also display quite serious behaviors of concern when dysregulated. The language used needs to include all persons with a disability and not be limited to those on the NDIS to best protect the public from harm.

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

Yes, within the domestic homecare sector, where direct care providers include family, friends, or self-arranged carers, it is important to reduce the risk among this cohort, and they should not be exempt from the legislation surrounding restrictive practices.

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

Yes, there are known restrictive practices that can place clients at high risk of harm and are associated with adverse and catastrophic outcomes. [10]
Prohibited high risk practices as described by the NDIS commission on their high-risk practices position statement and includes:

- Basket hold - Subduing a person by wrapping your arm/s around their upper and or lower body,
- Supine restraint - Subduing a person by forcing them into a face-up position.
- High-risk restrictive practices include specific forms of physical restraint and punitive approaches. Some of these practices are prohibited by law in some states and territories.
- Any physical restraint that has the purpose or effect of restraining or inhibiting a person's respiratory or digestive functioning.
- Any physical restraint that has the effect of pushing the person's head forward onto their chest

- 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 joint.
- Aversive practices- 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

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.

Questions:

Question 7: Do you agree that:

• the framework should use the NDIS definitions of restrictive practices?

Yes, the ACNP supports a consistent approach to the application of the definitions of restrictive practices to prevent confusion and to ensure that the care provided during a time of crisis, where there is an escalation in behaviors (which cannot be managed with de-escalation techniques), are tailored appropriately for each individual client.

• the Senior Practitioner should have the power to issue guidelines that clarify how the definitions apply in different situations?

A senior practitioner who has suitable qualifications and training should be able to clarify the induvial clients' needs within each situation and after all reasonable and less restrictive options have been tried. (A clear definition of the minimum required qualifications for the role and scope of practice must be made clear). The ACNP would also suggest that each Practitioner is able to devise a stepped approach to restrictive practices which would involve a gradual and tiered method for intervention, ensuring that the least restrictive option is always prioritised. This approach begins with less intrusive de-escalation strategies and applies the more restrictive intervention/practice when deemed necessary, based on the individual's specific behaviors and the level of assessed risk /potential for harm for staff, the community and the client. Ongoing assessment and review during each episode must ensure to allow for the earliest

de-escalation and removal of restraint once the client becomes more settled.

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?**

Yes, the ACNP supports the inclusion of detailed BSPs generated by the Senior Practitioner if the role of the Senior Practitioner is appropriately qualified and trained and credentialed for the level of autonomy required for generating the BSP. The key principle of this approach is that any intervention should be proportionate to the risk involved and should be continually reassessed during the implementation of the BSP. It emphasises a commitment to always applying the least restrictive intervention, in line with the individual's rights and well-being.

- 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?

Yes, the Senior Practitioner and Behavior Support Practitioners must be appropriately qualified to understand all aspects of the situation. For example, in a hospital, the use of restrictive interventions must be authorised by an authorised psychiatrist

- Should there be any specific provisions relating to consultation in the development of a BSP, in addition to the requirements in the NDIS Rules?

Yes, specific provisions relating to consultation in the development of a Behaviour Support Plan (BSP) should be included in addition to the requirements outlined in the NDIS Rules. These provisions can ensure that the plan is holistic, person-centred, and aligned with the individual's needs, preferences, and rights. Key elements to consider might include:

1. **Consultation with the Individual**: The client's support person, or carer should be involved in the process, where possible, to ensure that the persons autonomy, wellbeing and safety are central to the plan.

2. **Collaboration with Multidisciplinary Teams**: Involving professionals such as psychologists,

medical practitioners, social workers, and other relevant experts ensures that the BSP reflects a comprehensive approach to the individual's care and support needs.

3. **Ongoing Consultation and Review**: A process for regular review and consultation throughout the implementation of the BSP should be established and remain consistent. This allows for adjustments to be made as the person's needs or circumstances change, ensuring continuous person-centered support. This is particularly important during transitions of care where the BSP must be clearly articulated to the receiving team/carer etc.

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

Nurse Practitioners (NPs) play a central role in achieving a consistent and holistic approach to caring for those with a disability and can be pivotal to de-escalation. NPs utilise client-focused care through their advanced clinical skills, knowledge of their patients, and extensive experience required to address the clients physical and emotional needs. Their role is vital in ensuring the ongoing care needs of clients are met in a compassionate, effective, and collaborative way. Engaging with NPs is a crucial step in assisting the NDIS is maximizing NP workforce utilisation in-line with the National Nurse Practitioner Workforce Plan by improving consumer access to NP services and in meeting the National goals of removing barriers to NP lead care.

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.

Question 10: Should APOs be empowered to either:

• authorise 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 there 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?

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

The Models suggested are reasonable although the 2-step model needs a definitive timeframe around final 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?

For client safety and to ensure availability for a broad range of clients, it would be beneficial for APOs (Authorised Program Officers) to be permitted to act as consultants to multiple providers rather than being required to be employed by a single provider. This approach allows for more efficient and expert resourcing and a more flexible and diverse provision of services, enabling clients or service providers to access the expertise of APOs when required. Furthermore, safeguards should be established to ensure that the privacy and confidentiality of client information are maintained. APOs should adhere to strict data protection protocols when consulting multiple providers to prevent any unauthorised sharing of information.

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?

Yes, the ACNP supports the use of emergency use protocols, but it is crucial that these practices are only used when absolutely necessary and for the shortest possible time to ensure the safety and dignity of individuals. There should be a policy in place that, if emergency restrictive practices are implemented, a robust system is established for a timely review. A Behaviour Support Plan (BSP) should be conducted as a priority, ideally within one month, rather than six months, as this timeframe is too long. Additionally, there are currently no guardrails around the use of restrictive practices during this period, including how often they are applied per day or week and this is concerning.

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

Yes, the Senior Practitioner must be able to have the power to review or change the Authorisation if the BSP is not fit for the purpose for each individual.

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?

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?

To protect the well-being of the client, it is the duty of care of everyone involved in the person's well-being to have the right to seek a review of decisions related to restrictive practices. This includes not only the individual themselves but also any person concerned for their welfare, such as family members, carers, or advocates. Restrictive practices can have significant impacts on the individual's rights, safety, wellbeing and quality of life, so it is essential that there are mechanisms in place for timely and transparent review. The processes need to be transparent and in the best interests of client safety.

Furthermore, the ACNP believes that service providers should also have the right to seek a review of a decision not to authorise a restrictive practice, particularly if they believe that the decision may jeopardise the safety and well-being of the client or others. This ensures that decisions are being made based on the best available information and in the best interests of the person involved.

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

Yes, a person should have the right to request that the service provider review the Behaviour Support Plan (BSP) at any time. This right is crucial to ensure that the plan remains responsive to the person's evolving needs and circumstances and ensures that they have a voice and are heard.
Furthermore, a review does not necessarily mean that the BSP plan will be removed or altered, although the process will enable the client, where feasible, to have some level of autonomy.

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?

No, all complaints should be managed by an independent authority on a case-by-case basis.

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 respond to the misuse of a restrictive practice. As a key professional in managing and overseeing the use of restrictive practices within the disability sector, the Senior Practitioner can ensure that these practices are applied appropriately and within the boundaries of legal and ethical standards. Granting them the authority to address misuse allows for timely intervention, safeguarding the well-being and rights of the individual with a disability and to ensure that the recommendations from the DRC are adhered to, and that those with a disability have a voice and feel safe. Ensuring that restrictive practices are only used as a last resort and in the least restrictive manner helps prevent harm and supports better outcomes for individuals under care.

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

Via an independent review panel

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 Senior Practitioner (whose role must be clearly defined and credentialed) should have the power to share the person's BSP with the medical power of attorney, relevant medical, nursing, and allied health teams involved in care, schools, the justice system, support services and during times of transition of care, such as when transferring to a hospital or during times of assisted transport.

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 the reporting burden to the Senior Practitioner and the NDIS Commission be minimised?

Integration of IT systems and platforms using online reporting via a secure App which would allow immediate notification and reporting when an BSP or emergency behavior support intervention is actioned.

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?

The ACNP would like to highlight that those credentialed to be authorised as Senior Practitioners meet all educational requirements and possess the appropriate qualifications to work with clients in the disability sector. This is crucial to ensuring that Senior Practitioners have the necessary expertise and skills to perform advanced assessments, and provide high-quality, person-centered care. Given the complex and often vulnerable nature of individuals in the disability sector, it is essential that these professionals are fully equipped to make informed decisions, particularly when it comes to generating and implementing BSPs and managing restrictive practice plans. The right qualifications and training will ensure that Senior Practitioners can effectively navigate the clinical, ethical, legal, and emotional complexities of their role, thereby safeguarding the well-being and rights of the individuals they support.

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?

The Sanctions for the misuse of restrictive practices need to be thoroughly investigated by an independent review body. This ensures that any allegations of misuse are addressed impartially and transparently. An independent review process helps maintain accountability, ensures fairness, and upholds the rights of the individuals involved, while also identifying opportunities for improvement in practice and safeguarding against future misuse.

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

No, the proposed framework should not provide legislated immunity from liability for the use of restrictive practices, even if done in accordance with an authorisation and in good faith.

The Commissioner's behaviour support function plays a critical role in ensuring the responsible and ethical use of restrictive practices by NDIS providers. The framework must prioritise reducing and eliminating the use of such practices to protect individuals with disabilities from potential harm or exploitation.

Granting immunity from liability could inadvertently lead to misuse, as it may encourage providers to rely on restrictive practices without sufficient oversight or adherence to the established principles of behavior support. Immunity could undermine these efforts by reducing accountability, potentially encouraging behavior that deviates from the goal of minimising restrictive practices in favor of more ethical and less intrusive person-centered care.

It is essential to maintain accountability and transparency around the use of restrictive practices to ensure that they are only used when necessary. Ultimately protecting the clients' rights from unnecessary harm, with strict adherence to the DRC recommendations as outlined in the NDIS restrictive practices framework, ethical standards and guidelines.

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?

The senior practitioner must access regular training and professional development in line with any legislative updates or changes to the role. Regular auditing and performance review should be conducted. All providers should should undertake regular mandatory training and understand the need for ongoing audit and evaluation of BSPs.

Clear role definitions, including educational and training requirements need to be well defined for APO's, senior practitioners and providers.

The ACNP commends the recognition and thoughtful consideration of the contributions and value nurse practitioners bring throughout this consultation process. We highlight the critical need to address the ongoing limited awareness among the public and healthcare professionals regarding the existence, capabilities, scope of practice, and contributions of nurse practitioners.

Thank you for the opportunity to participate in this important review. We welcome further engagement and are available to provide additional clarification as needed.

Yours sincerely,

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