**Organisation**

Behaviour Change Consulting

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

Yes. If a young person has a positive behaviour support plan which includes restrictive practices, then the framework needs to include this setting.

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

Yes. If any person requires the use of restrictive practices, then this should be part of a positive behaviour support plan and the framework needs to include all the settings in which the person restrictive practices are implemented.

**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?**

It is common knowledge that the aged care sector consistently uses restrictive practices without a due process about why such practices are required or oversight on how these practices are being implemented including whether the outcomes of these practices are improving the quality of life for an aged care resident. Environmental restraints such as locked doors or wards are most commonly used and are often used by default for people assigned to dementia wards. In addition the use of routine chemical restraints are commonly used as is PRN medication. However, there have been reported cases of the use of physical restraint and seclusion and primarily used as a management tool due to poor staffing and a poor culture of care. This sector has an appalling history on duty of care and dignity of risk as has been revealed by the Royal Commission, so to leave this sector out of the new framework would be enabling this situation to continue.

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

There is clear documentation that shows when the restrictive practice is used and that the practice is part of an authorised positive behaviour support plan.

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

Basket holds, prone and supine restraints, pin downs, takedowns and any form of physical restraint that may impact a person's ability to breathe or pushes a person's head towards their chest or inflicts pain; any aversive practices that are noxious, unpleasant or painful; response cost procedures, limiting or denying a person access to community; overcorrection procedures, denial of key needs and practices which degrade or vilify a person.

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

Yes.

**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?**

Regardless of the model to be used, the guidelines which clarify the definitions of restrictive practices must be national guidelines which work across all states and territories.

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

* Ensures that the practitioner is appropriately qualified with specific training in positive behaviour support and applied behaviour analysis which includes antecedents and consequences, the science of reinforcement and differential reinforcement, the use of lease to most prompting, shaping and modelling, task analysis. data collection and how to use this to make changes, and functional behaviour assessment.
* Ensures the BSP covers all the content currently included in the Q&S Commission template.
* Ensures the rationale for the use of a restrictive practice is substantiated by frequency and intensity data on the behaviours of concern.
* Ensures there has been attempts to use other strategies which have been unsuccessful.
* Ensures there is a clear rationale as to why a particular restrictive practice is the LRA.
* Ensures that there is appropriate consent to authorise the use of restricted practices.

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

A BSP should also contain a one pager which sets out in a simple way:

* Who I am
* How I communicate and how you need to communicate with me
* What helps me have a great day
* Things that bring me some joy each day
* Things that I don't like doing

I also think that a page limit for BSP's would help!

**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. Most environmental restraints and well documented routine or PRN medications and some mechanical restraints such as those located in a vehicle.

**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)?**

There is an inherent conflict in this model if the practitioner is employed by the same organisation who the APO works for. Where this occurs, it will be necessary for an independent specialist to participate in the panel. I think the two step model could slow things down greatly.

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

The qualifications of the APO as described above are excellent, however, to achieve this will take considerable time and resources as many organisations do not currently have people with this skill set which is why the panel model with the IS has been working well in NSW.

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

I think the current Independent Specialist model in NSW is efficient and effective. This panel model is also used as a way to educate organisations and practitioners about restrictive practices, how to better write a BSP and what organisations can do to better manage and support staff who are working with very complex people.

**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 am assuming that an APO is employed by one organisation and is only responsible for that organisation. Given the current state of the sector in terms of human resources and costs, I don't believe an APO employed by an organisation would have the wherewithal to do APO work across a number of providers. If this was possible, there would be the potential for a conflict of interest to arise. On the other hand, if I, as an Independent Specialist could work as an APO then I would be able to work across a number of providers as I do now, therefore as a consultant to the NDIS provider.

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

Yes. I think 12 months is very appropriate, however, I also think there are some circumstances and practices which could be authorised for a longer term e.g. locked fridge or pantry in relation to a person with Prader Willi, or restricted access to fluids for someone with polydipsia. I agree that the emergency use proposal as explained in 5.4 is common sense.

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

No.

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

Yes.

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

Yes but these should not be necessary.

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

No.

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

Yes.

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

Yes, but only if a clear rationale is submitted as to why the BSP requires a review within the period of authorisation.

**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.

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

Yes.

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

Within the scope of restrictive practices, complaints should go directly to the Senior Practitioner who will have the power to investigate and implement the points noted in Proposal 11 with the final step being the complaint is referred to the Commission or Police if required.

**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?**

Department of Communities and Justice, Q&S Commission, Police, Department of Education, The Aged Care Quality and Safety Commission.

Where there are clear breaches of the legislation, and where a crime or a potential crime has been alleged.

**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?**

Yes. I am assuming that the Senior Practitioner "office" contains a body of suitably qualified people in positive behaviour support and restrictive practices who will be doing the bulk of the work and only need to refer to the Senior Practitioner position in cases where BSP's containing restrictive practices do not meet the appropriate requirements, there is concern that an APO has authorised a poorly developed BSP, there is a need for the Senior Practitioner to cancel an authorisation or refer to the Commission.

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

Good question.

1. Practitioners need to have appropriate training in PBS, applied behaviour analysis and restrictive practice.
2. Practitioners need to write quality plans using the content in the Q&S Commission template.
3. APO's need to be well qualified and experienced in PBSP and Restrictive Practices.

If these things can be achieved then the reporting burden can be minimised.

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

Yes - definitely. A high priority.

**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.

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

The Senior Practitioner model would manage all sanctions as in Proposal 10:

1. direct the provider to do / cease doing something in relation to behaviour support or the use of the restrictive practice,
2. cancel an authorisation,
3. refer the matter to the NDIS Commission, police or another relevant entity. AND
4. Suspend or recommend the suspension of the NDIS registration of a behaviour support practitioner.
5. Suspend or recommend the suspension of the NDIS registration of a service provider.

**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.

**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?**

I believe all providers should meet specific criteria which clearly shows they have the expertise to appropriately support people with complex needs and people who require behaviour support plans which contain restrictive practices.