**Name**

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

This proposal fails to consider the needs of children and families, and makes no mention of them.

The proposal is lacking a child centred, evidence based approach on how best to bring up children.

Indeed by its implicit criticism of parents it is undermining of their authority and doing harm to children.

Parents are responsible for their children's behaviour until the age of 16, and also have an authority if they continue to live at home.

There is a failure to consider the needs for safety of children and adolescents and the intervention to ensure safety is a greater priority than any concerns about restrictions. Is this legislation aim to stop parents from stopping children running across the road, or falling downstairs or taking poisonous substances? Yet do often young people with ID or ASD lack any decision making capacity greater than a 3 year old. Further parents have a role in teaching compliance and better behaviour. They are both responsible and the victim when a teenager assaults then, even causing significant brain injury, as occurred to my patient's mother last week. The problems of disruptive behaviour and conduct disorder are difficult and complex even in those with an intellectual disability or autism. It is a tragedy that NDIS does not collaborate in a child/patient centred manner, as used to happen before disability became a federal responsibility which has made it in capable of collaborating with state run mental health services. Even though lip service acknowledgement it given to parental authority, the professionally insidious and bureaucratic approach to restrictive practices is leading to a massive and naive epidemic of permissive parenting which is leading to the growth of family breakdown from violent insightless teens with ID/ASD that leads to requiring independent accommodation with 2:1 care 24/7, what the NSW Minister for Disability and Inclusion calls her 'million dollar kids', which is the inordinate cost of a lack of professional support for parenting of complex cases.

**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?**

The NDIS appears to work on the model of 'challenging behaviour' whereby are not considered to have a brain or neuropsychiatric existence, let alone a mind that might need psychiatric input.

The disdain that Mental Health is treated with by the NDIS is unacceptable, whereby any consideration of a mental health input is considered a restrictive practice. This is the context whereby mental health professionals are better trained and have review of professional standard in excess of the senior practitioner.

This is in the context that people with Fetal Alcohol Spectrum Disorder have a life expectancy of 35, and it is thought that 10% of suicide involves those with ASD.

The guidance of the Restrictive Practice Guidelines is tantamount to tell parents they cannot say no to a child, although in those with disability and communication problems this involves more complex skills.

The evidence shows that chillout and time out are important empirically proven parts of parenting. It takes account of an attachment and approaches to stopping maladaptive behaviours are a critical part of parenting that confirms that attachment still exists in separation and also leads to reparation of relationship. Mark Dadds has also shown that this is also a critical component of parenting even in those children who have trauma history, and it is just as effective in helping such children.

The failure of any community organisation to support any appropriate restrictions is leading to a massive overuse of emergency services, police and in due course juvenile justice and prison services, because of the lack of support for early intervention and parenting skills.

Further violent teens should not be admitted to hospital which by design is a restrictive and traumatic setting, and any out of control kids should be provided for in a homely setting by DCJ with intensive family and multidisciplinary intervention.

The harm of restrictive practices guidelines is cost shifting to health the failure of community management and support. The formalisation of any such process will lead to a complete breakdown between child and adolescent mental health services and NDIS and DCJ.

**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)?**

The lack of consideration of children, adolescents and families, let alone the complexity of mental health problems just means that this proposal is unacceptable and unworkable, let alone the consequent cost to the community in terms of carers who themselves will be assaulted.

As the head of the statewide tertiary mental health service of 40 years experience, I speak with authority. I shall not be beholden to a moralistic ideology that is harmful and lack a child orientated evidence based approach to helping children and adolescents with intellectual disability and ASD.

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

The notion of restrictive practice guidelines has been around for years. In my view restrictive practice guidelines is to ensure best practice restrictive guidelines. You cannot bring children up without some restrictions, as a necessity for safety and learning of the security of their parental relationship.

There is also an abject failure to provide early intervention, particularly in parenting skills, and emotional and socialisation programs and in other skill building approaches. our own research shows that mainstream approaches to early intervention and prevention are not effective in this population. In the same vein, the recommendation that special education should be done away with is completely indicative of the popularist approach to disability, that is devoid of any evidence based understanding of the emotional and behavioural disorders that occur in ID and ASD.

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

No. there are sufficient laws on assault in common law.

I still lament the interagency interdisciplinary approach that NSW had prior to NDIS. This is still needed, and 'foundational supports' funding should re-institute the good will and professionalism that existed, This included a high risk register of complex cases with regular reviews and elevating to a tertiary interagency clinic if needed. There needs to be on going expertise in disability, complex behaviour and mental health, with training in particular of specialist skills in a patient centred way, with innovative approaches to research to modify treatment to this special need population.

The textbook that I edited with Donna White and Lesley Whatson (2011) and the 500 clinicians that we trained in the state taught me that the developmental and family approach that we described, including mental health skills is very widely recognised and accepted. Yet when I have written to the royal commission or the senate enquiry to express my concerns, I have hardly been recognised as having contributed. This only confirms for me that the NDIS is a populist movement that is ante any evidence based approach or professional expertise. The diagnostic overshadowing of a model of challenging behaviour only reinforces the notion that mainstream mental health services have nothing to contribute. It is however highly discriminatory of the disability of human rights of children and adolescent with intellectual disability. Mental Health is totally inadequately funded, but highly skilled, and unless the NDIS/DCJ is actually interested in patient centred interdisciplinary/interagency care, then the NDIS, despite its massive level of funding, will fail the mental health and complex behaviour needs of young people with ID/ASD.

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

The consultation paper does not consider children/adolescents/families, neuropsychiatry, mental health, collaboration, evidence base and should be dispensed with.

**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?**

As far as I am concerned the senior practitioner is not qualified to pass judgement of medical and mental health expertise and has no concept of the reality of raising children and adolescents with ID/ASD.

Perhaps it should exclude anyone under the age of 18 years.

The option I have when I am providing a tertiary and last resort help to a family and the NDIS professional wishes to criticise me, I consider their view and the impact of their intervention, but if it is not helpful, I give the family the choice of working with the NDIS or with me. My life is too short to be trying to influence NDIS clinicians. However I have a statewide reputation of helping families, and an independent review of our service by the Social Policy Unit of UNSW (2024) found that we had had a huge impact on improving children and adolescents with behaviour and mental health problems especially with behavioural advice and the role of medications, as well as capacity building of other services and education eg with seminars with 1000 attendees.

One has to appreciate how rapidly the medical and mental health evidence is growing. for example before 2004, DSM diagnostic rules prevented the diagnosis of ADHD in ASD, but now we know that at the age of 7-8 years, 85% of children with ASD have a significant psychiatric diagnosis. The evidence also suggests that a failure to treat in primary aged young people affects the prognosis in adolescence.

We need real leadership to improve the mental wellbeing of children and adolescents with ID/ASD that is empirically based and enhanced by further research. It is evident that this will not come from the Senior practitioner and this proposed legislation.

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

The senior practitioner should play a role in training and supporting the level of professionalism of NDIS employed staff, but also look for practical child/patient centred monitoring of high risk situations and working to enable further interdisciplinary/interagency collaboration.

Parents remain the ones in charge of intervention and should receive advice on a range of multimodal, multidisciplinary intervention.

Undoubtedly DCJ continue to have a major responsibility to manage child abuse and neglect and to work with all parties to try and support families to survive the special challenges of raising children with ID/ASD.

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

Yes: training, risk audit and management, collaboration interdisciplinary and interagency, research, promoting tertiary expertise in disability/ASD.

**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)?**

If we had collaboration this wouldn't be needed, (like we had for 15years 10 years ago).

No: this prescriptive/legalistic approach will make the situation only worse. We rather need greater skills, collaboration and empirical approaches to helping troubled children, with the aim to prevent, where possible family breakdown. this includes an expansion of alternative models of care such as residential respite and shared care.

We know that there is a significant rate of murder suicide in these families, and skilled empirical support in required not some form of moralistic legislation.

**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)?**

Of course there should be prompt, even urgent support and authorisation of restrictive practices.

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

It is the wrong approach.

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

Interagency collaboration and tertiary review if needed.

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

This is a clinical and empirical question, not calendar based decision.

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

Each discipline and agency has its own professional standards and safeguards and should not be accountable to a separate agency.

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

Enough of these cases already have to go to the administrative tribunal, creating more work for lawyers, when we need interagency, interdisciplinary collaboration and review processes.

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

This is the wrong approach.

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

Ridiculous, for children and adolescents that is the role of DCJ.

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

More collaboration and clinical expertise rather than complaints.

**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 worst approach is to make it public information, damning services rather than having a role to enable review based on need. but maybe this is part of the problem of an advocacy/financial approach to disability, rather than a needs based approach.

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

Support and collaboration of recognised expertise, not reporting and legalistic processes.

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

There is continued need for training and education for all disability employees, and further development of outcome based funding.

**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?**

Senior practitioner cannot override parental legal authority or decision making except if they are committing significant abuse or neglect, which is the responsibility of DCJ.