SUBMISSION TO THE NSW DEPARTMENT OF JUSTICE AND COMMUNITIES' CONSULTATION ON RESTRICTIVE PRACTICES

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Submission By

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About Dr Jeff Chan Consulting

1. Dr Jeffrey Chan is currently a director/principal of Dr Jeff Chan Consulting. Dr Chan has extensive industry and practice leadership as a Senior Executive in Government and non-Government contexts.

2. Dr Chan has more than 20 years of experience as an international subject matter expert in the reduction and elimination of restrictive practices, and in upholding the rights of people with disability. In collaboration with several academic and colleagues, he has co-led the Australian research internationally in the rights protection and prevention of the use of restrictive practices, and in rights-based behaviour support.

3. He has held two inaugural statutory roles in the protection of people with disability subject to restrictive practices and compulsory treatment orders in Victoria, and in Queensland as a Governor-in-Council appointment as the Director of Forensic Disability and Chief Practitioner, in protecting the rights of people with cognitive disability subject to forensic detention orders and restrictive practices. More recently, Dr Chan was the Deputy Commissioner at the NDIS Quality and Safeguards Commission (the Commission), since the inception of the Commission.

4. He was a Finalist in the Australian Human Rights Commission's Human Rights Award in the Individual Community category in 2010 for his work in the reduction and elimination of restrictive practices.

5. Dr Chan is a thought leader in this specialist area as evidenced by more than 80 research publications, technical reports and book chapters in this area; including conceptualising and initiating several State and national administrative grants, innovative projects and research that are considered the first such initiatives in Australia.

6. In addition, Dr Chan has significant and extensive experience in providing contemporary and evidence-informed authoritative advice at Department Secretary level and senior officers, to Disability Ministers of States/Territories and Commonwealth agencies on rights-based legislation and practice, and on clinical intervention of persons who present with complex needs that interface with public health, mental health, justice and children services.

7. He holds an Adjunct Professorial role at the University of Queensland's School of Education. He was also Adjunct Professor at the University of Sydney's Sydney Medical School at the Centre for Disability Studies.

Overview of the Submission's Key Guiding Principles

8. The underlying foundation of 'authorisation' as the principle for the regulation of restrictive practices is appropriate. The authorisation needs to be clearly grounded on the United Nations Convention on the Rights of Persons with Disabilities (CRPD), (2006).

9. It is critical that the 'consent' model is not to be applied in the authorisation process, this argument is clearly explained and well-argued in the Queensland Public Advocate's reform options paper (https://www.justice.qld.gov.au/public-advocate/our-advocacy/disability/restrictive-practices-in-disability-services).

10. In my practice and professional view, and interpretation of the CRPD, the notion of 'consent' in the determination of authorising restrictive practices is incongruent with *Article 12 Equality before the law* as the NCAT model of 'consent' and 'guardianship'

infers mental capacity, whereas *Article 12* intends recognition of legal capacity, that is, a person with disability is equal before the law. As argued in Dr John Chesterman's reform options paper, the notion of 'consent' is highly problematic, for instance, a guardian agrees to a regime of restrictive practices. This is not a contemporary model of guardianship and inconsistent with guardianship to 'walk in the shoes' of the person.

11. The existing NSW Draft Exposure Bill has serious flaws in this respect of 'consent' and the withdrawal of consent following authorisation. It will potentially lead to fatal repercussions if implemented for the person, the behaviour support practitioner and the provider. It is important to exercise caution in the notion of consent due to ideological arguments.

12. It is essential that the proposed Senior Practitioner model is seen as the 'peak' authoritative clinical practice leader with all the legislative powers and funding to implement the legislative functions, and to support sector capability in NSW.

13. It is important to note that an authorisation of restrictive practices as an approach need to begin with supporting practice culture change in the sector, and collaborate with the sector to deliver change than a strictly regulatory compliance model of a 'tick box' of meeting procedural, policy and standards. The inaugural Victorian Senior Practitioner model places particular emphasis on sector culture change, such as, the distribution of "Dignity Grants" provided to providers and practitioners to implement alternatives and solutions rather than considering restrictive practices.

14. People with disability, particularly people with intellectual and developmental disability access services in more than one setting and contexts. As such, their rights need to be protected when it comes to restrictive practices regardless of the setting.

    Hence, the proposal of extending rights protection in the authorisation regulation across settings is the correct and sensible. At the same time, providers and practitioner will require support and capability development funding to ensure the seamless protection of the person's rights across settings.

15. Supported decision-making must be enshrined in the legislation to ensure that the person with disability subject to restrictive practices are involved in the decision process when restrictive practices are being considered, and to be presented with the opportunity to dissent and disagree with the decision to use restrictive practices.

16. It is important to highlight that 'chemical restraint' is a 'prescriber problem', it is not a practitioner and or a provider's problem. It is timely to re-think the notion of 'chemical restraint' given the high prevalence and over-use of medicines used to control behaviour, and the irreversible side effects on the person.

17. It is critical to re-think 'chemical restraint' approach as a 'public health problem', and not a disability provider issue. There is substantial merit to propose that any person subject to psychotropic medicines should undergo an independent medical review by a panel made of an independent medical specialist, the person with disability and their support network, a behaviour support specialist and an advocate.

    The current practice regarding restrictive practices requires a behaviour support practitioner to develop and train staff on the chemical restraint use protocol. Behaviour support practitioners are not medically trained and it places an unreasonable practice burden on them. The current regulatory compliance places the onus of a 'chemical restraint' protocol on the behaviour support practitioner and the presenting risks is

situated with the practitioner when it is the medical prescriber that prescribes the medication to the person.

18. Adoption of any principles and authorisation procedures must be developed from the lens of people with disability and that their voice is included in any proposition of the legislation. For example, whilst reviewability by NCAT of the Senior Practitioner's authorisation is an appropriate and commendable procedure but reviewability of the authorisation of restrictive practice ought to be simple and accessible for the person, and ought to occur at the level when a decision to use restrictive practices is being considered.

19. Simplify the authorisation process and ensure harmonization of the process with other State/Territory and the Commission's process. Currently, there are varied authorisation processes. This variation presents a degree of complexity for providers who have national services reach.

    The variation in authorisation processes impedes market growth and capability, and innovation because providers are unreasonably having to meet varied regulatory compliance regime that present slight nuances in implementation and inconsistency of decision-making.

    The lack of simplicity and clarity in authorisation processes often result in providers having to spend additional funding to meet the regulatory variance.

    NSW DCJ could consider advocating as a State to seek harmonization of authorisation processes nationally so as to minimise regulatory burden, and promote appropriate funding and pricing to ensure a thriving NDIS market.

20. Finally, the dignity of the person subject to restrictive practices must never be compromised and negatively impacted.

Specific responses to the consolidated list of questions and proposals

21. The Proposals 1 and 2 are fully supported.

22. Question 4 is fully supported.

23. Question 5 – Additional principles that merit inclusion:

    a. A fundamental principle is upholding the dignity of the person. Where and when the dignity of the person is compromised and negatively impacted, then the use of restrictive practices needs to cease and require an independent review.

       For instance, a person is fearful of being 'secluded' (e.g., an Indigenous person) or have no access to amenities that resulted in the person being severely and visibility traumatised, or resulted in the person urinating in the seclusion room. This illustrates that the dignity of the person has been 'taken away' and as such, it breaches the fundamental rights of the person.

       Another instance is the proposal to use mechanical restraint (e.g., a 'onesie') for a person with pica behaviour or constant exploratory touching of the body. The mechanical restraint is used during community access and is visible to the public, this practice compromises the dignity of the person.

b. An important principle to include is for practitioners and providers to consider the impact of the use of restrictive practices on the person and its impact over time. The impact can range from physical, emotional and psychological factors. For instance, a female participant has had a traumatic experience of sexual assault by being held down with straps. Hence, a consideration to use mechanical restraint should not be recommended because of the prior experience as its use of trigger trauma again.

c. Cessation of the restrictive practice(s) when there is no serious risk of harm posed, and or when the behaviour of concern cease.

d. Prolonged use of restrictive practices over more than two years (or shorter) require an independent review. The focus ought to be assisting providers to develop and implement 'capable environments', and promote positive behaviour support as a starting basis, rather than the current emphasis on restrictive practices.

e. In addition to the concept of 'serious risk', it is important to add 'imminent' risk as a factor, particularly in the provision of support for people with the interface of justice health and forensic background.

f. The notion of 'serious risk' requires further elaboration to guide practitioners and providers.

g. A behaviour support plan funding and pricing of services need to be results-driven, that is, the practitioner and provider are funded when there is a reduction of restrictive practices.

h. The quality of life of the person requires monitoring as over time, the continued use of restrictive practices can severely impede learning, development, safety and well-being. And inadvertently, promotes 'learned self-helplessness'.

24. Question 6 – Additional prohibition of restrictive practices should consider the following:

    a. Prohibiting the use of physical restraint and seclusion on children, especially in education and OOHC settings. There is substantial research evidence of the deleterious impact on the physical, mental and emotional development of young children, including the brain development and the increased risk of trauma.

    b. Prohibiting the use of restrictive practices in persons with mental health conditions, particularly persons with a known trauma history.

    c. The above should be applied to Indigenous peoples.

25. Question 7 and Proposals 3 and 4 are fully supported.

    In addition to Question 7, it is instructive and prudent to include in the proposed NSW legislation that the Senior Practitioner has the legislative mandate to determine that a particular practice is a restrictive practice (if it is not within the current NDIS legislative definition). This is useful because it is not atypical that a particular practice may emerge for a range of reasons and motivation.

    It is also critical to make a clear distinction that there are some practices are determined as abuse, neglect and coercion. For instance, there is an emerging discourse to include

'psychosocial restraint' as a restrictive practice. 'Psychosocial restraint' is an abuse and coercive control as clearly defined in the domestic violence literature.

Hence, it is prudent legislation to include a clause that the Senior Practitioner can determine a practice as restrictive, even if it is not in the existing NDIS legislation. The decision by the Senior Practitioner needs to be based on a rights-based approach, contemporary research and assists the provider to remove the practice in a collaborative manner.

26. Question 8 is supported. However, the notion of 'certain qualifications' present an implementation risk because behaviour support practitioners come from varied and multidisciplinary professions.

    In the development of the Commission's PBS Capability Framework, it is important to highlight that people with disability emphasise experience in disability, personal values and professional attributes as opposed to the emphasis on qualifications.

27. Question 9 – the quality of behaviour support plan ought to undergo an evaluation of its quality using the plan quality tool developed by Professor Karen Nankervis, University of Queensland. It is based on an administrative grant conceptualised and initiated by the author when he was Deputy Commissioner at the Commission. There is sufficient evidence to suggest that a better plan quality can lead to modest reduction in restrictive practices. This research has been led by Australian researchers and practitioners.

28. Proposal 5 appears to be an administrative artefact, such as the funding requirement to ensure success of the Senior Practitioner.

    The proposition presents a list of risks. For example, the APO role in Victoria presents implementation issues, such as qualifications, experience, conflict of interest, risk to APO if the APO's employer persists with higher use of restrictive practices to name a few of the risks.

    The best practice standard to simplify process and for authorisation to go directly to the Senior Practitioner as per the NT Senior Practitioner model, but I am mindful of the authorisation volume and workload in NSW.

    The emphasis should be on simplicity and clarity of authorisation process, and a focal point of accountability in decisions.

29. Question 10, 11 and 12 present with administrative risks and regulatory burden. It adds a layer of complexity for the person, practitioner and provider.

    A distribution of the Senior Practitioner will add to an authorisation complication. For example. when there is disagreement, dissent, risk to undue influence, and conflicting views and how these are to be mitigated and addressed.

    It is important that the Senior Practitioner model as the peak clinical practice leader is the single point of accountability. This single point of clinical practice accountability is essential to avoid potential risk to the practitioner whose views may differ from the APO and or may inadvertently agree with the APO. However, what happens when a critical incident occurs, who is the accountable officer when there is disagreement?

30. Proposal 6 is an administrative artefact and as intended will complicate the process. The notion of 12 months duration is not based on the evidence. Hence, it is administrative.

Furthermore, it presents a number of risks as it is dependent on a range of factors, such as the complexity of the behaviour presentation, the severity of the risks, the age of the person, the physical health and fragility of the person, or the type of restrictive practices.

31. Proposal 7 and Question 13 – 'emergency use' ought to be based on a range of principles, such as safety of the person, clinical judgement and other associated risks depending on the environment and context of the need for emergency use.

    It is also important to highlight that the Commission's Rule regarding 'interim behaviour support plan' has inadvertently resulted in interim behaviour support plans that are more than 50 pages long. There are a number of reasons that have given rise to the extensive pages of behaviour support plans, an example often cited by providers is an 'over caution' to meet national regulatory compliance obligations and erring on risk adverse approaches.

    The more appropriate term is a 'response plan' as per the PBS Capability Framework. An initial 'response plan' is a clinical and practice mitigation against existing risks, and is not intended to inadvertently become an interim behaviour support plan that is pages long. Typically, a 'response plan' in my previous clinical practice is about four pages maximum.

32. Proposal 8 and Question 14 are fully supported. Suffice to add the important principle of safety and dignity of the person are not compromised, and the authorisation of the restrictive practice can be withdrawn if the dignity of the person is negatively impacted.

    Another principle to consider is the accumulative effect of the use of restrictive practices, and where there is evidence that continued use will significantly impact on the person. These principles should guide the Senior Practitioner to consider withdrawing authorisation.

33. Proposal 9 – in the first instance, a person can disagree with the proposed use of restrictive practices at the stage of behaviour support planning. This is where it should occur in the first instance and there is evidence that supported decision-making process has been used.

    The right to review must occur at the fundamental level of behaviour support planning, and the review process should be documented. The next process is then to the Senior Practitioner in the first instance and good practice requires the Senior Practitioner to engage with the person's support network.

    Whilst the right to review by NCAT is appropriate and commendable, by its nature as a quasi-judicial body makes the procedure for reviewability onerous and daunting for the person with disability and provider. Secondly, NCAT may not have the clinical subject matter expertise in authorisation matters. Whilst there is merit for an NCAT process, it needs to be simplified for the person and relevant stakeholders.

    An issue to consider is funding, that is, will NDIA fund the practitioner and provider in an NCAT review process? If this route is taken, then it is very likely that the process will be time-consuming, is additional cost in preparation and presence before a tribunal, and adding a layer of regulatory burden.

34. Question 15 – agreed.

35. Question 16 – agreed.

36. Question 17 – agreed.

37. Proposal 10 and 11 are fully supported.

38. Questions 18 – 22 are legislative decisions that present risks that require discussions with the relevant authorities, e.g. referrals to professional associations for misconduct or poor practice. The important element is for the Senior Practitioner to have visibility and oversight, and the legislative mandate to carry out its function in its own right; particularly where there is imminent risk to the person.

39. Proposal 12 is fully supported. It would be a constructive principle if the Senior Practitioner adopts the role of supporting and building sector capability, and provide solutions with the providers.

    Noting that regulatory compliance does not equate to quality service provision.

    The Senior Practitioner need to have a role in applied research to build sector capability.

40. Questions 23 – 25, the propositions are supported and agreed to, on the caveat that the dignity of the person is paramount to the decision and no immunity should be afforded if the dignity of the person is compromised based on the evidence.

41. Question 26 – the simple answer is No because in the current regulatory environment, providers are burdened with complicating requirements and a lack of clarity in terms of meeting regulatory obligations.

    Furthermore, at this phase across Australia, the national regulatory infrastructure and systems do not support providers in being efficient and effective in reducing and eliminating restrictive practices.

I am willing to offer consultation and clarification on the submission if required.

Thank you for the opportunity to provide a submission.

Yours sincerely,

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Note:

Research references specific to this area can be found on www.drjeffreychan.com