**Name**

Geordan Nicholson

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

Yes. The out-of-home-care (OOHC) setting is a setting which is further removed from scrutiny than disability service provision. OOHC settings are likely to involve one or two carers who, in the case of foster or kinship care, are closely related and therefore less likely to report adversely on one another. The OOHC setting is a particularly vulnerable setting for people with disability due to often involving a lack of physical oversight.

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

The framework absolutely should cover the: Health and Aged Care settings. As a health worker, I have experience in both of these settings. I have seen that there is often misuse, unneeded threats, or a lack of understanding of restrictive practices and their consequences. There should be oversight of restrictive practices in both settings. In the health setting, there should be mechanisms which allow for rapid implementation and review of restrictive practices, so that there is not unreasonable delay in the process. The framework should also address disabilities in correctional settings, to ensure that persons who are in custody are not treated as "misbehaving" when they are, in reality, displaying symptoms of their disability. For example, inmates with Autism Spectrum Disorder may be treated as misbehaving, and therefore punished with chemical restrictive practices (e.g., capsicum spray) when they are suffering from repetitive behaviours or a 'meltdown'. This should not be permissible unless as a last resort and only with an understanding of the person themselves, and where other strategies have been attempted.

**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?**

Restrictive practices in the aged care setting can be misunderstood and therefore not implemented in accordance with law. The provision of restrictive practices only with the consent of substitute decision makers can prohibit the effective maintenance of aged care facilities. For example, if a substitute decision maker does not consent to physical restrictive practices for a person with dementia who is not compliant enough to allow for necessary bed changing (e.g., they are violent and aggressive to staff, and unable to mobilise out of bed), aged care workers could be stuck with the choice of either breaching the law or allowing an aged resident to continue to live in unethical conditions. If the law were consistent with the disability service setting, restrictive practices in these circumstances could be permissible, and the regulatory oversight could find much better ways to address behaviours that create difficult circumstances.

**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)?**

I believe that recommendation 6.35(b)(i)(1) could be problematic when there is an imminent risk of severe harm.

Needing to "explore and apply" other strategies prior to restrictive practices could, legally, cause disability services to expose people with disability to severe harms. For example, I am conscious that these requirements may mean that disability support workers are not legally permitted to stop a child with a disability from running onto a road or climbing up a dangerous height. There should, therefore, be provision for unexpected, imminent risk of serious harm where restrictive practices are permissible with regulatory hindsight and in accordance with the remaining three principles.

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

The threat of restrictive practice should be treated similarly or identically to the actual application of the restrictive practice. I have witnessed threat of restrictive practice being casually used in the Health setting as a matter of convenience for staff. This is immoral and should be regulated as well.

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

I believe that the Appendix B of the consultation paper is the best starting point for a list of prohibited practices in all settings.

However I believe that in the Health setting (and, by extension, certain Aged Care settings where healthcare is provided), the physical restraint (c) may be necessary in limited circumstances to apply other, authorised restrictive practices. For example, a chemical sedative may be authorised for use on a person. This authorised practice is effectively meaningless as, without the ability to pin a person's arm down, the sedative cannot possibly be administered.

I believe sedatives may be necessary to NOT prohibit, as I envision certain extreme cases, some of which I have personally experienced, where a sedative was the only possible solution to a severe risk of harm (however other strategies were used to obtain consent and compliance prior to administration of the sedative in that particular case).

Life threatening physical restraints should be prohibited in all settings under all circumstances.

With the above modifications, the full recommendation 6.36 of the Disability Royal Commission's final report should be implemented.

**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?**

Yes. This is absolutely necessary considering the broad range of environments which I believe should involve regulation.

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

The Senior Practitioner should have the power to prescribe certain additional or more detailed information for inclusion in all BSPs as well as where needed with specific BSPs or classes of BSPs. This power should be subject to some ministerial oversight, but I do not believe that prior restraint would be appropriate in determining what information the Senior Practitioner can or cannot prescribe.

The Senior Practitioner should have the power to require certain qualifications, information or training from practitioners, as well as have the ability to bar practitioners for perceived failings. Qualifications could have specific scopes and classifications, such that, for example, not all practitioners require qualification or training in certain physical restraints, however any practitioner who wishes to prepare a BSP involving those physical restraints does require that qualification or training.

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

There should be, at a minimum, auditing of BSPs. Registration of all BSPs may be an appropriate way to provide for this auditing. Higher risk BSPs may be subject to more regular or scrutinous audits than lower risk BSPs.

**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)?**

Particular categories of restrictive practices should be able to be authorised by APOs without separate Senior Practitioner authorisation, but this should always be able to be subject to "veto" by the Senior Practitioner. I believe the delegated categories should be only determined by class or kind orders, and the delegated categories should not be determined by legislation, as the legislative system is not designed to provide rapid responses to small but necessary changes.

I do, however, believe legislation should be available to prohibit the delegation of certain restrictive practices. For example, if stakeholder feedback identifies certain restrictive practices to be both necessary to be available but also high-risk (for example, certain chemical sedation practices), this should be prohibited from being delegated to APOs by 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)?**

I do not believe this would be an effective model as communicated to me. The purpose of APOs is to relieve operational burden from the Senior Practitioner and to therefore improve the effectiveness of the Senior Practitioner's role. Requiring ALL cases to be finally authorised by the Senior Practitioner does not reap the benefits of the APO model.

I believe that a modified version of this model may, however, be effective for higher-risk practices. I have detailed this in a later response.

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

The first model benefits from improved delegation, and therefore less operational burden on the Senior Practitioner. The Senior Practitioner will therefore be able to make higher quality decisions benefitting from increased time available to them. However it does proportionally increase the risk of abuse by APOs, as it does not offer much, if any, oversight of APO decisions.

The latter model is too far in the other direction, where it no longer decreases the operational burden on the Senior Practitioner at all, however has improved oversight. The risk from this model is that the Senior Practitioner makes lower quality, more rushed decisions due to a large increase in operational burden.

Both models benefit from individualisation of BSPs, however.

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

A modified two-step model may be effective. Under this model, there are four classes of restrictive practices: prohibited (in all circumstances); Senior Practitioner–only, where only the Senior Practitioner can approve the use of the restrictive practice; Two-step practices, where APOs can provisionally approve restrictive practices followed by Senior Practitioner (or an independent delegate, discussed below) approval; and APO-delegated practices, where only APO approval is required. I believe the categorisation of practices into these classes should be the responsibility of the Senior Practitioner with Ministerial oversight, using class and kind orders.

I believe that it would be most effective to involve both an "APO" type of role as well as an independent person, ideally a delegate within the Office of the Senior Practitioner, in a "Panel" type of model, to approve BSPs. This ensures independent oversight of BSPs without overwhelming burden on the Senior Practitioner. It is important to ensure that the Senior Practitioner is not overburdened to ensure that they can continue to provide high-quality oversight.

Therefore I believe the best model would combine both of the above suggestions, involving both an APO/senior staff member and an independent person retained by the Senior Practitioner, with the four classes of restrictive practice offering a wide array of regulatory power.

**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?**

APOs should be permitted to be consultants to a number of providers, to allow for wide ranges of provider sizes. For example, a very small provider will not be able to employ an APO, whereas a large provider may be able to employ several.

I believe there should be a certain requirement of time spent with the particular person (the person who will be subject to the BSP) before a BSP can be approved. This will avoid abuse from organisations and APOs trying to avoid costs.

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

I do. I believe that emergency use of restrictive practices do not need to be followed by a BSP if the Senior Practitioner (or delegate, or the APO) are satisfied that the restrictive practice was only used under the emergency use provision due to a lack of knowledge or training on the part of the member of staff, and that appropriate knowledge and training has since been, or will be, provided to the member of staff.

This will prevent BSPs from needlessly being created when the emergency use could have been better avoided.

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

When the Senior Practitioner has determined that the particular restrictive practice is unacceptable to the Senior Practitioner, considering the restrictive practices principles and the particular nature of the case.

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

Yes. This should absolutely be the case.

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

Yes. There must be ample options to review these decisions.

I believe that there should be a further option of review, which is a formal review by a court, due to the nature of restrictive practices being an action taken against a person without their consent (which, when not permitted by law, is called an assault and is dealt with under criminal law).

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

The rights to seek review for authorisation should be open to ANY person who has any concern for the person's welfare, no matter whether the concern is well-founded or not.

The right to seek review to deny authorisation for a restrictive practice should be limited to those who have a real chance of being impacted by the lack of authorisation.

**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, within reason (e.g., barring obviously vexatious or frivolous requests).

**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 they should.

**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 also have the power to require certain persons to undergo additional training.

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

It should be complementary to the NDIS complaints framework and coordinated with the NDIS.

**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 NDIS Commission, in all circumstances.
* NSW Police, in circumstances where there may have been unlawful assault and the Senior Practitioner determines that the most appropriate response to the unlawful assault is criminal in nature instead of educational.
* The Children's Guardian, where the person who was affected by the action is not an adult.
* The Health Care Complaints Commission and AHPRA, where the complaint involves a person subject to the jurisdiction of either of those bodies.

**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?**

The Senior Practitioner should absolutely have the ability to audit delegated decisions. The Senior Practitioner should not necessarily be required to actually view and personally approve all delegated decisions, but should have immediate access to records of these decisions when the Senior Practitioner sees fit to review any of them.

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

The Senior Practitioner should be able to delegate many of their functions, but there must always be mechanisms for the Senior Practitioner to audit the use of their functions.

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

Yes.

**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?**

The Senior Practitioner should have this power. The Practitioner should be entitled to prosecute in cases of gross misuse, but should also be entitled to require additional training and education to rectify the chances of future misuse, where this is appropriate, in a model similar to that which governs health practitioners.

**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. This will avoid disputes, but must be very carefully worded in order to ensure that cases of gross negligence or recklessness are not afforded the immunity.

As an analogy, police officers are generally afforded a great deal of immunity, and this often provides them with immunity when they act without education, forethought or appropriate levels of care. This must not be the case for restrictive practices.