Good afternoon,

I am writing to provide feedback on the proposals (/ statements of intent) that are detailed in the consultation paper regarding authorisation of RPs in NSW. I am a behaviour support practitioner with 7 years' experience in the role and also hold a tender as an independent specialist. I hold some serious concerns about some of the proposals in the consultation paper, and fear the decisions have in fact already been made.

- **Concerns re lack of public consultation regarding these changes**

  The change from a panel model to a Senior Practitioner model would represent a huge change in the way restrictive practices are authorised within NSW, and one that, I feel comes with many drawbacks and issues that the current consultation paper does not adequately address. I believe such vast changes should be proposed to the wider community for discussion and consultation before any changes come into effect. The current paper feels like "consultation after the fact" in that it seems these decisions have already been made.

- **RP authorisation across settings**

  I do feel it would be helpful to have the same authorisation processes across settings – as this would streamline authorisation and make expectations clear across all settings. I believe this would help to bring the focus back to the true reason for why RPs require oversight and authorisation (due to their infringement on human rights of PWD) and simplify what is currently a model of multiple authorisations processes, which ultimately results in gaps. Specifically in my role, I see that the use of RPS in the education setting certainly falls through the cracks and has no external oversight.

  However, in relation to proposal 2 regarding other settings providing an annual report to the SP – I can't see how this is going to do anything to actually work towards elimination and reduction of RPS, more just document their use in a more consistent fashion. I also can't see that, based on an annual report, the SP is going to be able to have any real, tangible oversight over the use of RPS in different settings. It appears to just be tokenistic/ data collection rather than specific committed action towards the UNCRPD agreement to work towards a reduction and elimination of RPs.

- **Prohibited practices**

  Yes, certain practices should continue to be prohibited as they are under the current model. These should be prohibited across all settings / have very clear guidelines, procedures and authorisation and monitoring requirements should they be permitted in one setting and not in another.

  In response to question 7 – yes, however these guidelines around how to apply the definitions should align with the guidelines from the NDIS Commission otherwise it is just duplication which adds unnecessary complexity to the assessment and decision making around RPs.

- **Senior practitioners' role in regulating BSPs**

  I have no issue with the authorising body for RPS, having the authority to prescribe that additional info should be detailed in the BSP before approval can be provided, **however this would require the SP to have very detailed and specific knowledge of behaviour support, functional assessment and the evidence base** (or the APOs if they are delegated to be able to authorise RPs) which I think is unrealistic in the current workforce market.

  If an SP or APO becomes an administrative role – where the expertise in behaviour support is lost/not a requirement of the role, then they will not have the required skills or knowledge to regulate BSPs to improve quality.

  Furthermore, I believe the NDIS commission are actually the national regulator for behaviour support plans – so I think it would be better for regulation to be left to one regulator rather than two.

  Another point later in the document references duplication of services as an issue to the 2-step process of authorisation; however, if the SP is rejecting authorisations based on plan quality – this will undoubtedly result in a lot more administrative work for implementing providers, and put strain on BSP funding – so I don't think the point of reducing duplication and financial burden to plans and providers stands by having a 2-step process (which would be the only way to try and mitigate conflict of interest) hold valid .

  I believe a more suitable authority would be for the authorising body, to have the power to decline an application for the use of an RP based on the quality of the plan and then refer the BSP practitioner to the commission / their supervisor for improvements to the quality of the plan.

  Where there are currently ZERO qualification requirements to operate as a behaviour support practitioner, it is, sadly, unrealistic to expect the quality of BSPs including RPs to be very good. To better address the DRCs recommendations – **proper upskilling of the BSP sector is required, just as proper upskilling of support workers is required.**

- **Senior practitioners and APOs**

  With the number of restrictive practices already in place in NSW I cannot see how a senior practitioner is going to be able to effectively oversee and authorise restrictive practices to move towards any sort of tangible reduction in their use.

  I **STRONGLY DISAGREE** that the APOs should be employed by the implementing providers as this poses a HUGE CONFLICT OF INTEREST RISK, which I do not believe the proposed countermeasures would effectively reduce. The notion that the APO works for the implementing provider entirely removes the critical aspect of INDEPENDENCE from the provider – which is a key part of the assessment and authorisation of a restrictive practice.

  The current IS/ panel model allows for true independence from the provider implementing the plan – which allows for more robust conversation about how the provider is going to implement the practice, and where appropriate justification and plans for how the practice will be implemented and monitored exists then authorisation can be provided.

I would have no issue with the IS being the person who holds power to decide if an RP has met the minimum standards of the NSW RP policy and procedural guidelines rather than a consensus model. **However STRONGLY BELIEVE this role should remain entirely separate to the implementing provider.**

In practice in my role as a BSP, I see time and time again, providers "covering their butts" and seeking information to justify that a practice is not restrictive or conversely, is restrictive – in order to suit their operational needs. If the APO was to work for the employer, there would be ZERO impetus for that person as an employee to argue with / go against the pressures of their employer with respect to RPs. Furthermore, there simply would not be enough people to fill the roles of APOS – there aren't enough adequately skilled BSPs in the state, let alone enough people with adequate behaviour support knowledge to fill a whole set of roles as APOS.

Also, who is going to fund these APOs? Creating this role would mean paying these people full time salaries- and there is no provision for that in the NDIS funding plans. It would just add another overhead to implementing providers, who are already reporting challenges with remaining commercially viable.

Furthermore, it would be necessary for the APO to have a strong knowledge of BSP to effectively be able to complete this role. If this role became administrative; again, it disconnects the authorisation process from the true intention of the UNCRPD to reduce and eliminate restrictive practices.

Again, with the number of restrictive practices in place in NSWs it is entirely unrealistic to think that a single senior practitioner can effectively oversee the work of the APOs – particularly if APOs are given the power to make decisions on RP authorisation without secondary approval from the SP. The only way I see this could possibly work effectively is if the 2-step process of authorisation were implemented.

- **Removal of interim authorisation**

  I have no issue with the notion of an emergency use process for restrictive practices that aligns with the NDIS practice standards and BSP rules for unauthorised use of RRPs. However, I do not believe monthly reporting on these to the SP is adequate. I also see this as HUGE DUPLICATION of reporting requirements for implementing providers, who are obligated to report on the use of URPs to the commission.

  I believe there is still place for interim authorisation of a restrictive practice – in line with the NDIS BSP rules. Often RPs are required (or are already in place) when a BSP takes on the case, and it is legislated that authorisation is required to be obtained within 1 month. I believe the NSW authorising body should continue to have oversight over these interim authorisations, where the provider and BSP is required to create a comprehensive, full application within 6 months.

  There is a difference between true URPS (emergency uses) and interim RPS (where an FBA and CBSP has yet to be completed but the restriction is being used routinely/ regularly). Removing interim authorisation thus removes an entire cohort of RPS from NSW oversight.

  I strongly believe that authorisation should still be Interim and Comprehensive – as this aligns with the NDIS BSP and RP rules 2018 legislation which governs the work of BSPs. I then believe emergency processes should be reserved only for URPS where a BSP is not yet engaged, or where the practice is used in a crisis and further assessment is required to determine if it should continue for authorisation or be ceased.

- **Ability of anyone to seek review of a decision first to the SP and then to NCAT**

  Whilst this proposal seems palatable to the general public, the reality is that many caregivers and NDIS providers still do not understand the impacts of restrictions upon PWD and likely wouldn't know when to seek a review of a decision, unless the restriction was very apparently breaching their human rights. I strongly DISAGREE that this proposal does anything to mitigate the risk of an APO employed by the implementing provider from authorising a practice without proper independent oversight as to whether that practice meets the policy and guidelines. Implementing providers WILL give authorisation to RPS that do not meet the current policy and procedural guidelines if the APO is an employee of the provider, and there will be only very distant oversight of their decisions (one SP simply cannot effectively oversee all APO decisions) – that is a given fact.

Moreover, shifting the review to NCAT (an already overburdened system) will be futile in reviewing RPS decision and will likely result in timely waits, whilst the authorised RP remain in use. Furthermore, shifting review to would require that NCAT employed behaviour support experts to assess these applications, as, again, having an administrator with no knowledge of behaviour science, FBAs, the evidence base, or how the practice would truly be used in practice, is pointless to say the least, and again entirely misses the point of the UNCRPD's commitment to the reduction and elimination of RPs.

- **Senior practitioner to investigate misuse of RPS**

  I believe this role falls to the NDIS commission as the regulator of NDIS providers who would be implementing the RPs. Ability for the SP to consult more collaboratively with the NDIS commission in these cases would be beneficial. I do believe there should be some sort of escalation process if the person reviewing the application to authorise the use of the RP has genuine concerns about misuse of this practice i.e. escalation to the commission or police. However, it should then be up to them to investigate and take action.

  Adding this power to the SP will only add additional duties and costs to the role and could easily lead to duplication of services across regulating bodies.

- **Panels being duplicative of BSP resources and putting pressure on the behaviour support employment market.**

  I do not agree with this point at all and feel there is insufficient justification for this point made within the consultation paper.
  Currently the BSPs resources require they complete an FBA and comprehensive BSP (per NDIS RP and BSP rules 2018 legislation) and then attend a 1-hour panel to provide evidence about how this practice meets the policy and procedural guidelines to warrant its inclusion in the plan and use in the life of the PWD.

  With the proposed SP and APO model, and the proposal that the SP can provide directions to the BSP to improve the plan, this could easily result in multiple applications to the SP for authorisation (as is seen to occur in Victoria), depleting BSP resources.

  Restrictive practice reduction and elimination should be a priority of BSP services, thus funding to meet RP approval needs should be prioritised within the funding. AND, if there is insufficient funding from the NDIS then application for additional funding based on the presence of RPS should be provided – this is a NDIS responsibility and until some pressure is put back to the NDIS to fund appropriately when there are RPs, cost cutting and plan reductions is only going to continue.

  Moreover, the only way that conflict of interest could possibly be mitigated to a potentially acceptable level is if the SP has to authorise all practices that an APO approves – meaning duplication of services but shifting the cost to the Department instead of the NDIS.

  Likewise, shifting review to NCAT (who don't have the resources or skills currently to decide if a RP meets the minimum requirements for authorisation) simply shifts the cost to NCAT instead of the NDIS. It doesn't reduce costs – in fact it likely increases them and increases the timeframes where potentially questionable RPS are being used, whilst awaiting review by the SP or NCAT.

- **Removal of consent from PWD or their decision maker**
  This again, reduces another level of oversight into the use of restrictive practices and puts the responsibility solely onto the SP or APO (who may have a vested interest due to their conflict of interest by working for the implementing provider).
  This also links back to the point I made above re reviews of decisions – how are decision makers going to know about the use of RPs in their loved ones' lives, if consent requirements are removed?
  Does this then put the responsibility onto the BSP to ensure that key decision makers are informed and consent? How is this appropriate when the BSP is essentially a consultant and doesn't work for the implementing provider?

In summary my major concerns about the proposals are:

- **APOs being employed by the implementing provider** – the conflict-of-interest risk simply cannot be mitigated to an appropriate level if the APO is not independent to the provider.
  This proposal alone does not satisfy point C of the DRC recommendations 6.35 that "the use of restrictive practice should be subject to independent oversight and monitoring." And concerns me greatly. The only way I could see this conflict of interest being slightly mitigated is by the two -step process proposed in the paper, or by continuation of the panel model where a truly independent person with expertise in behaviour support attends the authorisation meeting.

  The SP and NDIS commission could, and should, provide training to providers about making high quality applications for authorisations, to ensure providers are fully aware of their requirements when the sign up to provide services under Module 2A – which would promote a consistent approach, instead of pushing this onto APOs (who's skills and knowledge is going to vary dramatically). Having an APO fill this need is dangerous.

  There is simply no plausible way that the SP can retain adequate oversight of APOs through monitoring functions; or at least the paper does not sufficiently explain how this would be effectively achieved.

  I understand in Victoria all APOs are employed by the Department – likely on a full time basis, which increases cost to the Department where the workload to authorise all RPs may not require a full time cohort of employees, or conversely may lead to delays in authorisation. This again, raises the concern of skills and qualifications of APOs.

- **Qualifications/ experience of the APO and SP** – The SP and APO must have very in-depth knowledge of behaviour science, functional behaviour assessment, the evidence base and the NDIS legislation, NSWs policy and procedural guides and the overall rationale of the UNCRPDs commitment to the reduction and elimination of RPs in order to effectively work in this role.
-
- Simply having a degree with no BSP knowledge and experience is NOT ENOUGH – and will lead to shoddy approvals of RPS based on lack of skill of the APO.

- **I feel this consultation paper and proposed changes represents a tokenistic attempt to meet recommendation 6.35 without truly considering the application of these changes in practice** and the risk they pose to PWD without adequate consultation with the broader public and those directly working in the RP space currently.
  - There is insufficient justification proposed of how, in practice, a single Senior Practitioner can have appropriate levels of MEANINGFUL oversight and MONITORING into the use of restrictive practice, beyond box ticking.
  - How is the SP going to protect and promote the rights of PWD? And promote compliance? And authorise all RPS? And investigate complaints? And provide education and guidance?
  - How is this truly going to translate to real life reduction and elimination of the use of RPS in the lives of PWD, per the intention of the UNCRPD?

- **Removal of consent**
  I believe the decision maker(s) for whether a RP is used should have the power to decline an authorisation if the minimum requirements for authorisation are not satisfied when the application is reviewed, however firmly believe the participant or their decision maker should still be required to consent to the use of the practice within their lives – this is the essence of person-centred support.

- **Removal of interim authorisation –** removing this, removes a level of oversight of practices that are not an emergency use, but are in place whilst a thorough assessment of function and CBSP is obtained. Blurring in emergency use URPS and interim authorisations will muddy data collection about the use of RPS, and the identification of insufficient resources. i.e. if there are 1000's of emergency authorisations because there are no BSPs to do the work, this will not be identified, as the interim authorisations are mixed in. This also is not aligned with the BSP and RP rules 2018 legislation which stipulates that where an RP is in use a provider must seek out services of a BSP asap, then once a BSP is engaged an interim plan must be completed within 1 month. Taking this away will reduce oversight into BSP and providers compliance with the timeframes set out in the BSP and RP legislation.

- **Upskilling of BSP workforce** It is the responsibility of the NDIS commission to upskill the BSP workforce and implement trainings, and more stringent requirements for people to work as a BSP. If the RP authorisation body could work in conjunction with the NDIS commission this would be great however, but if it works independent it will lead to duplication of services for BSPs (if the SP / APO declines applications due to quality of the BSP) – which is being promoted as one of the benefits of the SP model.

- **Duplication of reporting** Providers are already required to report to the commission about their use of RPS so I'm not sure that adding in reporting to the SP monthly is doing anything to address the duplication of services that paper seems to promote as justification for the proposed changes.

- **Immunity from liability** – If an APO is employed by the provider but are given immunity from liability – then this is going to open the floodgates for improper authorisation of RPS which will do nothing to reduce and eliminate the use of RPs, but poses a huge risk to, in fact, increase risk of harm to participants. There is no guarantee, nor should there be an assumption, that APOS would work ethically or independently of their employer and may be subject to pressures to authorise practices etc based on business needs (i.e. to reduce work comp premiums) rather than the rights and needs of PWD.

If there is opportunity for the cohort of current NSW independent specialists to meet with the policy writers, for a group discussion about this consultation paper, I believe this would be welcomed.

Kind Regards,
Laura Parkes
Director and Behaviour Specialist
NDIS Practitioner (Advanced): P0003391
BCaBA; CBA-U; PBS Supervisor

[redacted]
www.pbss-newcastle.com.au
Please note my work hours are Tuesday to Friday 8.30am – 4.30pm.
I will respond to any correspondence received outside of these times as soon as possible upon my return