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

The proposed legislative framework should cover out of home care setting.

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

Government in education, healthcare, aged care and justice settings need to provide an annual report to the senior practitioners and contractors inclusively of any other setting.

**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 issues and challenges faced by the authorisation of restrictive practices are: in education, misbehaving students due to their mental health condition or disability or that they cannot learn to talk, read and write; in youth justice, the violent behaviour by teens and adolescents because of their schizophrenia, delusional disorder and other psychotic disorders; in aged care, the elderly patients getting lost even within the aged care centre by forgetting their bed number etc; in health, a person suffering from intermittent explosive disorder when anger management has become a problem to relationships; in out of home setting, when the patient does not know how to or cannot access certain public facilities (for example ramp to substitute for stairs). The understanding of patients’ special needs and sensory processing issues that arise when restrictive practices are being used are important in analysing the problems faced. For example, a patient does not want to be confined on a restrictive chair for long periods.

**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, I support the proposal in the DRC Recommendation 6.35(b), restrictive practices should only be used in the last resort when all other friendly behavioural support methods fail to effectively reform the patient as hoped.

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

Restrictive practices therefore should be limited to restraining violent patients or patients with a sleepwalking disorder when nocturnal duty is scarce. Such patients could pose a threat to the people around them and themselves. Restraints like this of extreme confinement in nature needs to be as short of a duration as possible.

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

The proposed restrictive practice framework therefore, should not be used in any other setting other than restraining unconscious threats that are out of the patients’ control. Restrictive practices are not to be used in educational, cognitive behavioural, and therapeutic settings if the client does not have any urgent need to.

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

The NDIS can use the definitions of restrictive practice as long as it is in easy English, reasonable to understand and have a defined purpose of the practice.

**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?**

The words used should include some everyday spoken words and worded normally for example, in the Commonwealth level of English understanding in Australia without substituting easy English with hard to comprehend terminology.

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

Senior practitioners have certain roles to undertake accordingly with the NDIS behavioural support plans such as cognitive behavioural therapy, emotional management therapy, educational and speech therapy all tailored for the patient to further their skills in managing independence and social skills depending on the disability and what the patient needs. The information will be provided based on the patient behaviour, culture, background, personality and condition of the disability. To become a qualified NDIS senior practitioner, will depend on the nature of the job and the required education and work experience. Provisions for the consultations in the development in BSP include form filling from parents, friends, and mentors of patients with disabilities, to let the practitioner know which specific needs the patient has. Therefore, there is no one size fits all approach. Within the restrictive practice regime, there is a balance between excessive use of restrictive practice and the prevention of threatening behaviours that arise with aggression.

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

The BSP should focus mainly on cognitive behavioural therapy as this affects or improves their mental health in its most significant proportion. A prompt diagnosis of a specific mental health condition or disability can improve behavioural outcomes of patients with special needs.

**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)?**

Under any circumstances, the APO cannot undertake restrictive practices without the approval of senior practitioners as this can create unintended consequences for patients whose needs are different to those assumed from the APO. A qualified senior practitioner is required to provide all the information about the patient with disability to the APO before any restrictive practices are applied. Only a physical restraint chair and a lock bed, for example, be used in extreme and rare cases of patients posing a noticeable threat to the community.

**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)?**

A two-step model is strongly recommended as it provides certainty between the senior practitioner and the APO regarding the patient with disability.

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

The benefits will include improved behavioural outcome, more reasonable thinking patterns, friendlier social skills and being able to get over sensory issues. The risks are, that the patient will be deprived of former repetitive and restricted interests they once enjoy.

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

There are alternative approaches such as the use of non-coercive cognitive behavioural therapy that guides the patient to sobriety and recovery from for example, substance dependence disorder or to improve on areas short-fallen by patients. The procedure will also help patients fight cravings for certain repetitive interests and learn to move on from.

**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?**

The APO can be employed both by a single and by multiple providers depending on the patients’ circumstances and needs and the options available from the APO. This is depending on whether or not the service provider has more than one patient/participant as a group.

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

The standard 12 month period of the NDIS plan is consistent with the financial year beginning in the 1st of July to 30th of June next year. Restrictive practices are included in the BSP only when absolutely necessary.

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

If the patient no longer needs restrictive practice; the mentor or provider fails to provide accurate or adequate information regarding the need for restrictive practice to the APO; the information provided was incorrect or misleading by mistake; the provider has breached the condition of authorisation; and the NDIS provider has breached the provision of legislation, the APO can have the right to cancel the restrictive practice when appropriate.

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

Authorisation decisions seeked by the NDIS providers should be open to senior practitioner internal review.

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

Authorisation decisions seeked by the NDIS providers should be open to the NSW Civil and Administrative Tribunal as for the consent of the patient with the disability agreeing upon a certain amount and type of restrictive practice.

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

No, anyone including the participants or patients involved in the NDIS program, service providers and senior practitioners all have the right to seek review of their own and each other's wellbeing as this is a priority in mental health.

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

NDIS providers have the right to seek enquiries to review the decision to use restrictive practices based on the wellbeing of their patients.

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

The patient can at any time, request the service provider for BSP support plans.

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

The senior practitioner should have the power to investigate and make a complaint and facilitate investigative functions regarding the misuse of the restrictive practice if it affects the wellbeing of the patient and makes their condition worse.

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

Senior practitioners should have the right to respond to the misuse of restrictive practices when they are unnecessary or abused among wrong patients.

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

A certified complaint form is required to provide details of the misuse of restrictive practices and submitted to the relevant person of authority to further their improvement in their use of such practices.

**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?**

For privacy reasons, the information about the patient should only be shared amongst senior practitioners, service providers, parents, close friends, and patients with the disability and remain strictly confidential.

**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?**

Reporting is based on the nature of the disability and the patient’s needs. As long as information provided by service providers to senior practitioners and the NDIS commission are accurate and thorough, they can handle and prescribe the best practices to help the patient through her or his adult life with the disability and to improve, for example, independent living.

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

Information should be accurate and clear in the first place to avoid confusion and burden to senior practitioners and the NDIS commission. It is also advisable to avoid using absurd or confusing jargon.

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

Yes, I agree to the proposed guidelines and standards as well as the expert advice about the use of restrictive practices and alternative behaviour support plans for the patient. Survey results should be published so that awareness is raised regarding the prevalence of certain types of disability and certain needs from patients.

**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, the practitioner can have the power to impose warnings regarding the misuse of restrictive practice as a precaution to what is happening with the patient when the practice is used upon.

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

Certain penalties are being suggested such as fines and loss of the position in the job title be imposed if the misuse of restrictive practices continue despite the complaint from senior practitioners. However, if the misuse of restrictive practice occurred only for the first time, the APO will then be issued a warning or notice about the impending penalties if they continue to disobey the restrictive practice regulations.

**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, the proposed framework needs to provide legislated immunity from the liability of the use of restrictive practices as long as it is done with good intentions and purposes for the patient. Such practices are therefore, regulated by criminal liability law.

**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?**

Service providers should only be required to do behavioural assessment and provide information to senior practitioners for the prescription of certain restrictive practices if appropriate. Service providers do not need to be subject to further requirements unless otherwise specified by the patient or service provider.