NSW DEPARTMENT OF COMMUNITIES AND JUSTICE

A legislative framework to regulate restrictive practices

Submission from:
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About Scope

Scope (Aust) Ltd ("Scope") is one of the largest not-for-profit organisations in Australia. Our origins stretch back to 1948, when a group of parents who wanted better lives and opportunities for their children with disability established the Spastic Children's Society of Victoria. The values these families championed are demonstrable and enduring, ensuring people are always at the heart of everything we do.

Scope's purpose is to create meaningful opportunities for people with disability to belong and thrive.

Today Scope supports more than 5,600 people with complex intellectual, physical, and multiple disabilities across metropolitan and regional Victoria and New South Wales. Our services include home and living supports delivered at 340 specialist disability accommodation sites. We also provide therapy, positive behaviour support, social connection, and employment and school leaver transition programs, along with disability inclusion programs tailored to corporate and community organisations.

Scope remains committed to amplifying the voices of people with disability. We always assume clients have the capacity to make decisions and exercise choice regardless of their disability. Our strategic business decisions and operational practices are also increasingly informed by the voice of the client. We have established a Client Participation Framework and Client Advisory Panel, and lived experience is represented in our governance and in our staffing. The voice of the client is fully embedded in our induction process for all staff.

Our practice is increasingly informed by evidence, and we remain committed to further enhancing our service delivery through research, understanding client outcomes and experience, and investing in quality and safeguarding including adoption of open disclosure principles and practice.

Scope is committed to providing support that is person-centred, protects human rights, promotes inclusion and opportunity, and encourages personal growth and individual expression. Scope believes that people with disability are best placed to make decisions about their own lives and articulate their goals, needs, aspirations, capabilities and strengths which determine service provision and recognise their contributions to the communities in which they live.

Introduction

The main purpose of this submission is to provide feedback on the detailed design of the Authorised Program Officer (APO) model proposed in the NSW Department of Communities and Justice consultation paper *A legislative framework to regulate restrictive practices*.

Scope has significant experience in providing support to people who receive NDIS funded services and are subject to restrictive practices. Scope has been working with an APO model since the *Disability Act 2006* (VIC) commenced in 2007. There have been several iterations of the APO model in Victoria since its inception. Following our acquisition of Disability Services Australia in December 2021, Scope has been delivering NDIS funded services in NSW; any restrictive practices used as part of the delivery of these NDIS funded services has been approved by a Restrictive Practices Authorisation Panel.

Currently, Scope supports 65 people in NSW and 658 in Victoria who have regulated restrictive practices included in their Behaviour Support Plan (BSP).

While this submission is focused on the use of restrictive practices with NDIS participants, the insights may also be applicable in other settings to which the legislation would apply, including health, education and justice.

Scope is committed to the aim of the proposed framework to reduce and where possible eliminate the use of restrictive practices. We appreciate the human rights dimensions related to the use of restrictive practices and always aim to meet or exceed our safeguarding obligations.

Scope endorses the principles detailed at DRC recommendation 6.35(b).

Authorisation model

Scope supports the adoption of a partially delegated authorisation model in NSW. This model should draw on learnings from the models that have operated in Victoria and South Australia, while making improvements that ultimately contribute to achieving national consistency in regulating restrictive interventions. The central reason for choosing a partially delegated model ahead of a two-step model is the unavoidable regulatory duplication that is intrinsic to the latter, as indicated in the consultation paper. While having formal endorsement from the Senior Practitioner would perhaps provide greater assurance in the appropriateness of all Behaviour Support Plans, and ameliorate concerns about the use of delegated authority, these factors are outweighed by the systemic advantages of building a community of practice among APOs through a partially delegated model.

The support structures required for a partially delegated model would in turn promote culture change across the sector, contributing to a reduction in and the potential elimination of restrictive practices. The Victorian Senior Practitioner recently responded to a recommendation that came from APO short course participants about the need for a Community of Practice and subsequently reviewed 91 related articles in a literature review. This literature review highlighted some of the benefits from establishing a Community of Practice including members learning from one another, providing mutual support, reducing their isolation, exploring new ideas together, and having the

opportunity to voice their opinions. Establishing an ecosystem that leverages collective APO knowledge would also feed into Senior Practitioner investigations of policy and practice solutions related to emergent concerns.

There are, however, several core elements that first need to be defined if a partially delegated authorisation model is to succeed. These elements include having clarity around the responsibility for authorisation and keeping the category classifications as simple as possible. Scope supports the rationale for using the NDIS definitions for restrictive practices with the awareness that many providers interact at the Commonwealth level, and with the objective of fostering national consistency over time. This would encompass the Senior Practitioner having the power to issue guidelines that clarify how the NDIS definitions apply in different situations.

Scope recommends that the APO alone approves all environmental restraints and chemical restraints, and both the Senior Practitioner and APO approve seclusion, physical restraints and mechanical restraints. These arrangements would for the most part replicate the authorisation process in Victoria and provide clear guardrails. The potential for causing psychological distress and physical harm to people subject to seclusion, physical restraints and mechanical restraints is significant and therefore requires that additional layer of oversight through the Senior Practitioner. Moreover, the ethical concerns with these three restrictive practices suggest that their use may inherently violate human rights, individual autonomy and dignity.

Having the Senior Practitioner work closely with the APO will lead to meaningful conversations that identify and address the risks and benefits of the proposed restrictive practice. As the APO should be better informed about the person and their circumstances this notionally improves the quality of decision making. Scope has a person-centred approach that emphasises the importance of gathering information about the person's lifestyle, skills, relationships, preferences, aspirations, and other significant characteristics, to provide a holistic framework in which appropriate, respectful and meaningful behaviour support may be developed. The strengths of this model rely on the combined clinical expertise and operational experience of the decision makers involved. Ideally, the Senior Practitioner would not be solely responsible for authorisation for similar reasons, other than in designated circumstances.

If there were to be exceptions in any categories these should be formally declared by the Senior Practitioner; for example, any chemical or environmental restraints that require approval from both the APO and the Senior Practitioner. The use of class or kind orders would be appropriate but as a supplement to the five broad categories of restrictive practice referred to above, which should be legislated. This varies from the current approach in South Australia.

Scope believes that requiring authorisation for different 'Levels' is problematic. An individual might, for example, be prescribed different chemical restraints at both 'Levels', and this increases the potential for error in the authorisation process. It would be simpler to advise that specified chemical restraints require authorisation by both the APO and the Senior Practitioner rather than first confirming the 'Level' of the chemical restraint being administered. Nevertheless, there is value in looking at the 'Level 2' exceptions defined under the *Disability Inclusion Act 2018* (SA) for certain environmental and chemical restraints and assessing whether those restraints require closer scrutiny from the Senior Practitioner, perhaps to the extent where approval is required from both

the APO and the Senior Practitioner. These exceptions, if there are any, should be specified and formally declared in publications by the Senior Practitioner.

This does not infer that the role responsibility for categories of restrictive practice will remain static. There may be instances where the aggregated data indicates that responsibility for a category of restrictive practice should sit with the Senior Practitioner alone rather than being partially delegated to the Authorised Program Officer, or vice versa. Evidence may also emerge about some restrictive practices, notably the evolving area of chemical restraint, that lead to their limitation or prohibition. The reasons for practice changes such as these should always be clearly explained in published materials. It would be preferable to designate in advance the circumstances that might give rise to practice changes.

The exercise of emergency use provisions outlined at section 145 of the *Disability Act 2006* (VIC), for example, highlights nuanced decision making that requires ongoing oversight from the Senior Practitioner. The *Victorian Senior Practitioner report 2022-23* notes that the 2019 reclassification of physical restraint from a "planned emergency" response to a "restrictive practice" had likely led to an increase in the use of physical restraint and a resultant decrease of oversight and safeguarding. Yet the review processes established by the Senior Practitioner meant that the reasons for this change were addressed through a subsequent physical restraint project with the objective of strengthening safeguarding in this area.

Authorised Program Officers

Scope proposes that where possible APOs should be employees of NDIS providers who meet set qualification requirements and have undertaken training accredited by the Senior Practitioner. For providers supporting lower numbers of people subject to restrictive interventions, the APO may be a consultant that meets the same set qualification and training requirements and may be engaged by several different organisations. The employment of consultants would probably be the only option available for providers in some smaller markets and rural and regional areas, and Scope acknowledges the operational difficulties and additional costs inherent in the partially delegated model for these providers.

Any APO, whether employee or consultant, should be subject to clearly articulated conflict of interest provisions. The Senior Practitioner would retain the power to approve, refuse or revoke the registration of any APO; and the refusal or registration of registration may lead to a banning order from the NDIS Commission.

Senior Practitioner

Scope considers it highly desirable to work toward and implement a national Senior Practitioner model. Scope suggests that the NSW legislative framework should be developed with this objective in mind. Such a model would for practical reasons continue with jurisdictional differences until an intergovernmental protocol specifying the interrelationship of roles and responsibilities across various jurisdictions was established. But these differences could be minimised over time and the goal should be to achieve harmonisation of the partially delegated APO and Senior Practitioner model, if not uniformity, across Commonwealth, state and territory jurisdictions.

There is an increasing number of disability providers operating in more than one state or territory, and other providers that already have a significant national presence. Delivering disability services across multiple jurisdictions may therefore entail duplicated reporting obligations for providers, including obligations arising from restrictive practices and behaviour support plans; and the associated resource, time and cost impost for these providers is not adequately reflected in NDIS pricing arrangements. This is also at a time when providers' operating margins are already very tight: Forty percent of the not-for-profit providers receiving NDIS payments above $20 million recorded their second successive (and increasing) deficit in 2024, and for more than half of these providers it was their third successive deficit. It is preferable therefore that any regulatory regime avoids duplication wherever possible.

Conclusion

Scope believes that a partially delegated authorisation model to regulate restrictive practices in NSW. This would entail APOs having authority to approve all environmental restraints and chemical restraints, while both the Senior Practitioner and APO would be required to approve seclusion, physical restraints and mechanical restraints. The development and implementation of this model should have a view to future national harmonisation and be consistent with the principles detailed at DRC recommendation 6.35(b).