**Organisation**

The Northcott Society (Northcott)

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

YES - A consistent approach to authorising and monitoring the use of restrictive practices across all settings for people with vulnerabilities such as cognitive, communication, physical and sensory impairments/deficits would hold all service providers accountable against a consistent standard irrespective of setting.

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

YES - health and education. While there are existing guidelines and legislation for these settings, they are not consistent with or as rigorous as the legislative framework for disability settings. People with disability are subject to RPs in those settings and a consistent legislative framework would facilitate a consistent approach and accountability.

**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?**

Accountability checks and balances vary across settings, as well the ability of service providers to remain current and accurate on the specific requirements for authorisation, compliance and best practice across authorisation frameworks. Different frameworks increase the possibility of exemption 'loopholes' emerging, further compromising the human rights of vulnerable people.

**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 - the principles recommended by the DRC are consistent with the principles we have been reinforcing in RPA panels and practice support across Northcott. The reduction and elimination of restrictive practice use must remain as a fundamental focus of service delivery.

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

The current compliance and regulatory framework for restrictive practices frequently translates as punitive for providers such as Northcott who actively comply with all reporting requirements with transparency and openness to collaborate to improve practice.

The principles of a 'Just Culture' (<https://www.england.nhs.uk/patient-safety/patient-safety-culture/a-just-cultureguide/>) applied in this context would be a powerful way to improve reporting and by extension, achieve the primary function of improving the quality of life of NDIS participants affected by restrictive practice use.

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

YES - specific restraints and practices outlined in the Position Statement –Practices that present high risk of harm to NDIS participants (Updated July 2023) by the NDIS Quality and Safeguards Commission. It would be useful for this resource to be further expanded with additional examples to highlight everyday harms that are overlooked in service delivery.

These prohibitions should apply to all service providers across health, aged care, education and disability.

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

YES - a nationally consistent set of definitions would go a long way to accurately measuring where we are as a nation in adhering to the UN Convention on the Rights of Persons with Disabilities.

**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 - assuming that the Office of the Senior Practitioner is collaborative and has insight into the various scenarios that present themselves in this space.

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

The regulation of BSPs is a significant gap in the existing framework. Currently, the burden falls on the provider to engage in all 'Reasonable Steps' to get a BSP in place for any customers who have unauthorised RPs. As a provider, there is limited recourse to holding practitioners to:

1. Delivery timeframes
2. Quality of the plan
3. Accuracy, relevance, accessibility and currency of the information included in the plan
4. Plan amendment where gaps are identified.

This would be the forte of the Senior Practitioner as the authoritative expert in this space. It would also hold all practitioners in the state accountable to the same standards of practice.

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

YES - work with the NDIA to articulate exactly what the end product to the customer should be, that is, what the minimum expectation is of the specialist/professional service. At present, when plans fall short or have errors, practitioners will cite a lack of funding as the reason that they cannot make any amendments. This is unacceptable because they have in effect, delivered a faulty product and the customer should not be expected to pay more for them to correct the faults. Similarly, practitioners will decline attending RPA panels because the funding has run out, again, this should be a service delivery expectation that is intrinsic to the BSP contract and accounted for in the unit price billed to the customer.

**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)?**

YES - the APO role should be competent to authorise routine environmental, mechanical and chemical restraints. These authorisations require active collaboration with other specialists and evidence to support the proactive application of a restrictive practice.

Mechanical restraints will often require specialist allied health input and having that extra scrutiny makes the authorisation process more robust. Similarly, chemical restraints must be supported by prescription by a medical practitioner, medication purpose forms, medication charts and polypharmacy reviews. Environmental restraints are assessed in situ by the behaviour support practitioner and operational management (of the service provider). Seclusion and physical restraints are arguably more intense/invasive restrictive practices and people with disability would benefit from a more stringent authorisation lens for those RPs (such as the Senior Practitioner) than most providers would apply.

**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)?**

Northcott’s concern with this model is that it may create a bottleneck for the authorisation process. The current process of RPA panel authorisation carries a significant administrative burden prior to panel, to ensure all authorisation requirements are met, as well as ensuring that the panel itself is as inclusive as possible with customers and their guardians/family members attending.

At Northcott we have a two-three week turnaround for authorisations once we get a BSP uploaded to the portal. Would the Office of the Senior Practitioner be able to maintain/improve this while applying the same level of rigor and scrutiny applied by the current process?

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

The Northcott RPA process has benefitted significantly from the inclusion of Independent Specialists as a mandatory component of the authorisation panel. Their professional expertise, insight and moderating influence in the panel context, as well as the education and feedback they provide to operational staff and behaviour support practitioners has been exemplary.

The APO model as described does not appear to include this provider-specific interface and it will be a loss to the process.

If behaviour support specialists were to become a part of the Office of the Senior Practitioner, then that would ameliorate this loss. Northcott is confident that if we could have behaviour support specialists available (via the Senior Practitioner's Office) of the calibre that Northcott regularly accesses, that would continue to make their expertise available to providers.

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

As mentioned previously, the current panel process allows for customers and their guardians/caregivers to participate in the panel discussions.

Northcott actively invites guardians and families to attend panel and share their concerns and ideas in the panel forum. Similarly, if a customer wants to attend panel, we will ensure that we schedule the meeting at a time they can participate.

Is there a way to integrate the proposed models with what we currently have in place so that the inclusiveness is not lost?

**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?**

A consultancy model is attractive because a well-trained, objective group of APOs would be working across providers, supporting practice improvement where the goal remains not to just authorise restrictive practices but actively challenge the need for them as well as exploring opportunities for active support and positive, pre-emptive practice.

The Office of the Senior Practitioner would have a quality-assurance approach, auditing decisions reviewing recommendations. They would also conduct regular training/education/competency assessment sessions to maintain a consistent standard of APO.

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

Proposal 6 - YES, this is a function currently determined by RPA panellists, taking into account time required to reasonably meet any conditions of authorisation (e.g. specialist report/review, data collection, incident reports).

Proposal 7 - NO, not required.

The proposal for emergency use of a restrictive practice is not clearly explained; under current guidelines and regulations, each instance of use of unauthorised restrictive practice (including those used on an emergency basis) must be reported to the NDIS Quality and Safeguards Commission (NQSC). All Reasonable Steps to obtain authorisation must also be reported to the NQSC - there is a 28-day report as well as quarterly reporting required along with daily/weekly reporting.

The interim authorisation process must be supported by an interim behaviour support plan developed by a registered behaviour support practitioner and the senior manager is accountable for their decision to authorise the practice.

All interim submissions and outcome summaries are managed on the DCJ authorisation portal and subject to scrutiny and audit at any time by the CRPT.

Proposal 8 - YES, the Senior Practitioner should have the power to cease a practice that is not required or does not meet authorisation standards. Currently, the RPA panel exercises this power, but this could be done better by a totally objective body external to the service provider, overseeing the application and rationale for the practice.

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

No comment.

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

YES - this would be useful if there are mitigating circumstances for authorisations that have been cancelled. Northcott has also had family members attend panel who have objected to the need for the whole authorisation process because they perceive the practice to be essential to the welfare of their family member.

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

NO - The NDIS Quality and Safeguards Commission is a central escalation point for complaints including dissatisfaction with panel outcomes and/or recommendations.

Including NCAT in the mix (in this capacity) feels like a duplication of resource; there is also the possibility that existing NCAT functions would be adversely affected with the added administrative burden.

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

YES - review should always be linked to the welfare of the person affected.

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

YES - if there is evidence that the impact of not using the RP would negatively affect the welfare of the person.

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

YES - the behaviour support plan must be a dynamic plan that evolves based on skill building and positive behaviour support strategies being consistently employed by service providers.

**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 NDIS Quality and Safeguards Commission already has this function - they provide notice of what it being investigated, visit the premises if required and interview personnel to make a decision on whether a practice should be ceased, the service provider issued with fines or deregistered.

Having a second complaints and investigation body would create an additional administrative burden that draws resources away from quality controls and assurances for no additional benefit.

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

YES - these are quite appropriate powers to exercise where RPs have been actively misused.

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

The Office of the Senior Practitioner should have visibility of complaints made to the NQSC/NDIA pertaining to restrictive practice use and behaviour support in NSW.

Transparency and collaboration between State and Federal bodies would allow for better auditing and oversight of service providers.

The aim, as always, is early identification and intervention where there are poor or unethical ('sharp') practices in play.

**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?**

Specialist reports may influence the use of restrictive practice; this includes allied health practitioners, medical practitioner and specialists, and NCAT orders. The Senior Practitioner should have the power to share information with the regulatory bodies for these groups particularly if there are patterns that emerge of RPs being recommended (or exempted from authorisation) with questionable rationales and frequency.

**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?**

YES - collaboration with the NQSC for NSW data would augment the Senior Practitioner's visibility of restrictive practice use without increasing the administrative burden on service providers.

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

* Avoiding any duplication of reporting requirements.
* Having intelligent systems' analyses of data submitted.
* Collaborating with NQSC for data they have.
* Updating existing systems so that bulk uploads for monthly reporting is possible.

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

YES - practice support in a post-ADHC world is a yawning gap because it is not funded by the NDIS. Northcott works with families, customers, and the community to have the common goal of reduction and elimination of restrictive practices; it is difficult where practices and culture are entrenched and there is so much fear around the 'what ifs' if a practice is reduced or removed.

**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?**

NO - but the Senior Practitioner should have a voice at the federal level to highlight repeated misuse and poor practice and escalate their concerns to the NQSC.

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

No comment.

**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 - but 'good faith' must be clearly defined.

**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?**

Registered service providers in the disability setting are subject to rigorous registration and compliance scrutiny. This scrutiny is amplified where all reporting requirements are stringently adhered to.

The Office of The Senior Practitioner presents the opportunity for active collaboration and support towards the common goal of reducing and eliminating RPs and improving the experience of a good life for the people Northcott supports.

Our recommendation is we use the Senior Practitioner in NSW to achieve a 'State of Excellence' and keep punitive functions at the Federal level for service providers.