# NSW – DCJ Consultation Paper feedback

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The consultation paper does not propose any alternative option than the APO / Senior Practitioner model. This consultation appears to only seek advice about how to make that predetermined position work.

Fundamental to the feedback is the need to question the assumption that the APO / Senior Prac model is the most appropriate. The proposal appears to be attempting to shift the cost of the current authorisation system predominantly to providers to manage in an administrative context. The proposed model does not indicate how the rights of the person subjected to RRP’s will be upheld in the suggested (compromised) model.

Expectations of APO’s are unrealistic given the volume of positions that would be required to meet NSW demand particularly regarding environmental and chemical restraints. Consideration should be given to retaining what works in the current model and addressing the areas that are problematic rather.

The focus should be on protecting the rights of the person with whom the practice is used – which is missing from the overall proposal.

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

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

The DRC recommendations only call out disability service provision, health, education, justice, and out of home care. The below also calls out residential aged care.

The Australian Law Reform Commission – 2014 Chapter 8 was exclusively focused on restrictive practices.

<https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-dp-81/8-restrictive-practices/restrictive-practices-in-australia/>

This review called out the inconsistencies across sectors including disability services, residential aged care facilities, hospitals, prisons and schools.

If the intention is that the model will overtime include this stated range of sectors, provisions for aged care services should also be included in the legislation.

**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?

Authorisation for the use practices with persons with a disability are reliant on efforts towards their reduction and elimination. This is based on the foundational premise that the person can be habilitated and supported to no longer engage in behaviours posing risk over time through a functionally educative approach. In an aged care context, a person’s gradual decline may cause them pass through a phase of behavioural disruption. Best practice behaviour support in RAC settings requires further conceptualisation.

An authorisation process for the use of practices with a RAC setting, which is predominantly a medical model institution, will require:

* consideration in the application of definitions of restrictive practices
* identification of best practice principles to ensure practices are the least restrictive and safest option
* measured efforts to reduce their use and impact on the person
* identification of the threshold for their elimination.

Extensive consultation will be required with both the Aged Care Quality and Safety Commission and the NDIS Quality and Safeguards Commission.

The disability sector is experiencing a trend of prescribing health professionals who state the use of a medication is for ‘treatment’ rather than ‘management of behaviour’ to support implementing providers to avoid the requirements associated with an authorisation process. Which results in many NDIS participants being medicated (sedated) in the name of treatment without the intended safeguards of the NDIS (Restrictive practices and Behaviours Support) Rules 2018 being applied. Associated risks identified by the aged care Royal Commission must be considered when developing an authorisation process for aged care residents.

The nature of residential aged care services will require a paradigm shift from a medical model of care to a rights-based approach.

**Proposals:**

1 – legislation should provide that the use of restrictive practices on NDIS participants in the disability service provision, health, education and justice settings should be governed by the principles recommended in by DRC Recommendation 6.35(b)

2 – the legislation should require government agencies in the health, education and justice settings, to provide an annual report to the Senior Practitioner on their, and their contractor’s compliance with the principles.

**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 the DRC Recommendation?

* Yes

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

* That the person or their substitute decision maker has consented to their use.
* **Where the person considers the use of the practice to be punitive and / or aversive the practice would, by definition, become prohibited practice**.

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

* Yes the legislative framework should prohibit practices. Determining the prohibition of specific practices in various settings should be done through consultation with peak bodies representing each sector. Safe support is likely to look different in different contexts under different conditions.
* Punitive practices in Appendix B of the Consultation Paper, point e) references denial or limit participation opportunities or access to community, culture, and language… may require a qualifying statement regarding its inclusion for the intended purpose of prohibition. The qualifier may be unless otherwise instructed by Court Orders.

**Proposals**

3 – the NDIS definitions of restrictive practices should be adopted for the NSW legislative framework

4 – The Senior Prac should have the power to issue guidelines that clarify how the definitions apply in different situations

**Question 7**: Do you agree that:

* The framework should use the NDIDS definitions of restrictive practices?
  + Yes. These are acceptable workable definitions that already exist in Commonwealth legislation, rules and regulations. Maintaining these will support consistent application and allow for like for like comparisons in reporting and consideration of human rights issues within and across sectors.
* The Senior Practitioner should have the power to issue guidelines that clarify how the definitions apply in different situations?
  + Yes. If the starting point for the legislative framework is for NDIS service provision with the view of increasing the breadth of application of authority across sectors, the NDIS Rules for these practices state that they will require authorisation as determined by the participating state or territory. This concept is consistent with the application of those Rules.
  + Practical application and good practice support will vary across sectors.

**Question 8:** What role should the Senior Practitioner play in regulating behaviour support plans? For example:

* Should the Senior Practitioner have the power to prescribe additional and or more information for inclusion in the BSP? If so what information?
  + Where the information does not sufficiently evidence the principles identified above. These principles are consistent with those expected within the NDIS (Restrictive practices and Behaviours Support) Rules 2018.
  + Only where sectors other than disability services have additionally legislated expectations to those outlined in Appendix A and the NDIS (Restrictive practices and Behaviours Support) Rules 2018.
* Should the Senior Practitioner have the power to require a behaviour support practitioner to have certain qualifications and the Senior Practitioners approval before they can prepare a BSP which will be used to authorise the use of a restricted practice? If so, what should be the additional qualifications and the criteria for approval be?
  + ONLY for those not required to have undertaken a suitability assessment by the NDIS Quality and Safeguards Commission. Expecting behaviour support practitioners delivering services under the NDIS to go through and additional regimen of proof of qualification or capability will be seen as a significant disincentive to continue to deliver services. More will join the exodus from the sector.
  + Where sectors have not been through the NDIS capability framework process a similar framework commensurate with C’wth expectations for NDIS practitioners would be appropriate across additional (out of home care, residential aged care, health care, education).
* Should there be any specific provisions relating to consultation in the development of a BSP, in addition to the requirements in the NDIS Rules?
  + Where not already required by the NDIS Rules, it would be appropriate to include information regarding the persons experience of the restriction and how that will be further mitigated.

**Question 9:** is there anything else the proposed framework should do to improve the quality of BSP’s?

* The NDIS Rules have resulted in a sector wide focus on identifying and reporting on restrictions, quite rightly. However, improvements in the persons quality of life are often overlooked. Practitioners are so focused on providing guidelines and do’s and don’ts that evidence driven measurement and comparison of improvements to the persons experience of a quality life are overlooked, forgotten, missing and often not discussed.
* Clear inclusion of information regarding how the restriction has been explained to the person. This should not be seen as the responsibility of the practitioner, it is predominantly the responsibility of the implementing provider, with support/input from the practitioner. Rather than contained within the BSP this can be attached to it and or the submission seeking authorisation.

**Proposal**

5 – A Senior Practitioner model should be structured to use APO’s of the authorisation process. An APO should:

* Have operational knowledge of how the BSP and proposed restrictive practice would be implemented
* Be required to meet prescribed professional standards set by the Senior Practitioner, and
* Be approved by the Senior Practitioner

**Question 10:** Should APO’s be empowered to either:

* Authorise categories of restrictive practices without separate Senior Practitioner authorisation (a partially delegated model). If so,
  + No. An APO model is flawed. There is an inherent conflict of interest for an APO model. Later in the proposal is criticism of the Interim Authorisation process that currently exists in NSW. This will be replicated and multiplied by the APO model. While there are ‘provisions’ in the expectation of APO’s being PBS trained, and required to meet professional standards, there is insufficient information to describe how this will not only be initially determined but monitored over time. There is an insufficient number of people trained in PBS to fulfil the demand for this role in the sector. Creating this number by training people will be a superficial response. Drawing experienced clinicians into the role will remove them from the limited pool of practitioners currently providing behaviour support services   
      
    APO’s will be employed by the implementing provider and therefore subject to internal pressures for the authorisation of the practice in the best interest of the organisation. This removes the current safeguard of an independent person in the decision-making process, a current feature of the NSW model and a highly valued feature by the sector, as highlighted by the 2019 sector consultation on an alternative authorisation model.   
      
    Implementing providers already have Authorised Reporting Officers who report to the NQSC on both authorised and unauthorised use of regulated restrictive practices. Many/most providers will either allocate the role of APO to the same person, creating a conflict of interest of roles, or create a situation in which the APO and ARO will be adds within the organisation. Providers will seek to resolve potential conflicts by determining which issue puts the provider at most risk, resulting in the authorisation of practices for provider benefit rather than protection of the person rights.
* Provide preliminary approval of restrictive practices, with final authorisation provided in all cases by the Senior Practitioner (a two-step model).
  + This is likely to confuse many implementing staff and ARO’s regarding the status of authorisation. This will also be compounded by difficulties in providing sufficient and timely evidence of authorisation to the NQSC Proda porta.
  + Why have the initial step if it needs the second step.

Any benefit of the above would be largely administrative for implementing providers. The above models to not have the rights of the person subjected to the rights violation. This model undermines the intent of the quality and safeguards of the Q&S Framework and subsequent rules and regulations. The range of risks within the APO model in Victoria should be identified with realistic mitigations before proposing the adoption of a similar model in NSW.

The model was considered by NSW disability services in 2018 and rejected.

A partially delegated model significantly increases risk for people with a disability who experience restrictions. Most identified restrictions are either environmental or chemical restraint. The likelihood of a Senior Practitioner office being across those practices to ensure that APO’s are making appropriate decisions is too large to be practicable.

In addition, when the NDIS was fully rolled out in Victoria, the APO model was already embedded due to Vic legislation introduced in the prior decade. The sector had many years to adjust to the expectation and then incorporate NDIS regulatory expectations.

In NSW providers, under NDIS funding constraints, will be less inclined to create new positions and seek clinically skilled staff to undertake the role, and more inclined to delegate responsibilities to an existing senior operational / administrative manager without the appropriate knowledge & skill base to carry out the intention of the function. This further increases the risk of conflict-of-interest decisions being made by orgs using such practices.

Consider:

RRP authorisation panels at two levels.

1. Senior practitioner independent panel consideration of high-risk practices – Seclusion, Physical and Mechanical Restraints
2. Senior practitioner representatives attend implementing provider panels consider Chemical and Environmental restraints. Staff within the office of the Senior Practitioner – as representatives of the SP, and alternatives to Independent Specialists. This would require the SP to hire and allocate the representatives to providers/panels.

During the 2019 sector consultation regarding the next RRP model for authorisation implementing providers (and families) wanted clinical expertise and independence to be features of the decision-making process.

What would be the benefits and risks of the above models?

Most commonly used and most commonly under-recognised types practice = ER and CR… risks in leaving APO’s with decision making responsibilities where risk management for the organisation is a conflict of interest to upholding participants rights.

Consent to the content of the BSP should be sufficient consent to the use of the RRP within the BSP. Therefore, consent model can be stepped down … authorisation however should come with consent to implement the BSP before an authorisation decision can be made. Still includes consent in the process but before and not after authorisation is considered. May hold up Interim Authorisation…. Is this a different decision-making framework than CBSP’s…

Two step model has the potential to overcomplicate the authorisation process, particularly when the second step has not supported the position of the first step … implementing providers would be confused and unclear on what they could/not use when & how.

INEPENDENCE OF DECISION-MAKING IS KEY. The proposal erodes the

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

**Question 12:** Should APO’s:

* be required to be employed by a single provider? Or
* be permitted to be consultants to several providers? If so,
  + what safeguards should there be in relation to this?

**Proposals**

6 – The Senior Practitioner and APO should have a discretion to determine the duration of an authorisation up to 12 months

providing it doesn’t extend beyond life of the plan

7 – there should be an emergency use process for RPs before BSP has been prepared or given authorisation, which should preplace the interim authorisation process.

makes sense for emergency use… but shouldn’t replace the interim process, it should allow for use while the interim plan is being developed and… can only have a 4 week ‘grace’ period – Interim plan still needed and subsequent comprehensive still needed.

Consideration would need to be given to whether it would be a URP in the absence of authorisation, or if because NSW identifies the ‘grace’ period as not requiring authorisation for 4 weeks if it sits outside of URP, until the weeks elapse without an Interim plan to be authorised or authorisation was delayed.

8 – The senior practitioner should have the power to cancel an authorisation for restrictive practices where:

* The senior practitioner has determined that there is no longer a need for the restrictive practice
* The senior practitioner requests evidence to demonstrate the restrictive practice is still needed and provider fails to provide sufficient evidence
* The authorisation was obtained materially incorrect or misleading information or by mistake
* The relevant provider has contravened a condition of the authorisation, or
* The relevant service provider has contravened a provision of the legislation

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

**Question 14**: Are there additional grounds on which the Senior Prac should be able to cancel authorisation

Are the above conditions enough to cover abuse, neglect exploitation from staff and misuse of the practice?

**Proposal**

9 – An affected person, the NDIS provider, and any other person who has a genuine concern for the welfare of the person may seek a review of an authorisation decision. The review rights would be:

* First to the Senior Practitioner for internal review
* Then the NSW Civil and Administrative Tribunal

**Question 15:** Should authorisation decisions:

* Be open to internal review?
* Be reviewable at NCAT?

**Question 16:** Should rights to seek review be limited to the person or a person concerned for their welfare? Should the service provider have a right to seek a review of. Decision not to authorise a particular practice?

Where a provider believes they and the behaviour practitioner have provided sufficient evident for the safe use of the practice, they should have a the right to request a review of the decision. The safe implementation of a RRP is for both the person with whom the practice will be used and all those others in the area/present during the presented risk. An organisation should have the right to challenge a decision where their legislated obligations are being held up and the safe service delivery to other participants and safe workplace obligations may be compromised by the Senior Prac’s decision.

**Question 17:** Should a person have a right to request the service provider review the BSP at any time

Yes, they should have the right to request a review at any time – with the understanding that the ability to review the BSP will be impacted by the availability of the practitioner and funding to conduct the review.

The right should come with an expectation that the purpose for the review is also clear, so that it ca be a targeted response to the request.

**Proposals:**

10 – The Senior Practitioner should have powers to investigate the misuse of restrictive practices, on receipt of a compliant and on its own motion.

11 – The Senior Practitioner should have the following powers to respond to the misuse of a restrictive practice:

* Direct the provider to do/cease something in relation to a behaviour support or the use of the restrictive practice
* Cancel an authorisation
* Refer the matter to the NDIS Commission, policy or another relevant entity.

Role of the NSW Senior Practitioner regarding investigating misuse, will require clear boundaries or defined roles between their investigative powers separate or in partnership with the NQSC. Is the intent to create a state-based replication of the NQSC, or to re-engage with the powers that existed prior to the NDIS across multiple govt departments

Yes, if the forward plan is to include use of RRP’s in contexts additional to those specific to NDIS participants receiving NDIS funded services from NDIS registered providers.

In NSW, prior to the full NDIS roll out, the NSW Ombudsman had powers to investigate such issues. An alternative would before either the NSW Ombudsman to conduct their investigations or the Ageing and Disability Commission with additional legislated powers. If their role extends beyond the NDIS service provision.

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

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

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

Bi lateral agreement between NSW and Commonwealth outlining roles, responsibilities, thresholds for involving state first, the commonwealth for more serious situations. Reports to be provided to the commonwealth.

**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.

* Police
* NDIS Commission
* NDIA
* ADC
* NSW Ombudsman
* Premier & Cabinet
* NCAT & OPG
* DCJ

**Question 22:** Are the means by which the Senior Practitioner would have visibility of the use of RP’s by NDIS providers proposed in this Paper sufficient? If not,

* what additional information should providers be required to report to the Senior Practitioner?
* How can reporting burden to the Senior Prac and the NDIS commission be minimised?

**Proposal**:

12 - The Senior Practitioner should have the following functions:

* Developing and providing information, education, and advise on restrictive practices to people with disability, their families and supporters and the broader community
* Developing guidelines and standards and providing expert advice on restrictive practices and behaviour support planning.

Responsibility for developing the information and education already sits with DCJ, so no significant change.

Standards and advise re RP’s and BSP need to be consistent with NQSC – which has the responsibility for defining PBS under the scheme… this may be confusing for providers… it may let NQSC off the hook for that a function and increases risk of BSP practice advice being contrary to advice provided by NQSC. May need a clear relationship for a possible shared responsibility… but why double the responsibility.

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

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

Only in the context of building on the advice and guidance from the NQSC. If extending beyond scheme participants, it should have the function,

**Question 25:** Should the proposed framework provide for a legislated immunity from liability from the use of RRPs where their use was in accordance with an authorisation and done in good faith?

**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.