**Anonymous Submission**

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

In instances of foster care, etc. where a caregiver is assuming the role of parent, the need for restrictive practice authorisation should not apply. Unless, as outlined in the consultation document, except to the extent that disability service provision setting overlaps with it. Example: a person in foster care who accesses the community with the support of an NDIS support worker. If Chemical Restraint is required, the implementing provider should seek authorisation and the NDIS support worker should report administration. The foster carer, however, should not be required to report administration.

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

N/A

**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?**

May potentially present as a problem for young people living in residential aged care settings. Otherwise, people shouldn't be receiving support across both settings.

I don't see there being an issue with the authorisation process/framework being the same, however, different guidelines regarding specific restrictive practices and how they are applied needs to be relevant to each setting – the differences between the needs of those with disabilities and the aged population needs to be taking into consideration.

**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.

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

Practices should be trauma-informed.

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

Yes. Physical restraints that are deemed to pose an unacceptable level of risk, such as basket holds and pin downs, as already deemed prohibited under NDIS guidelines.

The use of Seclusion for people under the age of 18 should be carefully considered on a case-by-case basis. There are instances in which the use of Seclusion for people under 18 years of age is the safest option to ensure the safety of the individual and/or others, however, current legislation does not permit this practice to be implemented for people under 18 years of age. Provided that the appropriate procedures and safeguards are in place, there are instances in which Seclusion poses less of a risk than other restraints (in particular, physical restraint). In such instances, the use of Seclusion should be carefully considered and weighed against the benefits and risks. Blanket prohibition of Seclusion for people under 18 years of age can be a barrier to service provision and client/staff safety.

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

Yes. The current differentiation between NSW legislation and the NDIS guidelines is impractical. E.g., the need to seek authorisation for certain transport-related practices in the absence of reporting obligations.

**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. Seeking guidance from the NDIS has a rather low success rate. Not only is their response time typically very long, but they are also often reluctant to provide any helpful advice or confirmation.

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

Should the Senior Practitioner have the power to prescribe additional and/or more detailed information for inclusion in the behaviour support plans (BSP)? If so, what information?

* Yes. Senior Practitioner should be able to request additional information on any subject within the BSP to ensure that BSP meets legislative requirements. E.g., more details about how a particular restraint is implemented, skill building strategies, fade-out strategies, data collection, allied health assessments, etc.

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Should the Senior Practitioner have the power to require a behaviour support practitioner have certain qualifications and the Senior Practitioner’s approval before they can prepare a BSP which will be used to authorise the use of a restrictive practice? If so, what should the additional qualifications and criteria for approval be?

* Qualifications? No. It’s evident that possessing certain qualifications and meeting the NDIS capability framework does not accurately reflect a practitioner's ability to develop a high-quality BSP. Mandating formal qualifications over hands-on experience is one of the biggest pitfalls of the disability industry. It often deems qualified, yet inexperienced, people more suitable than those with practical experience implementing behaviour support; this is reflected in BSPs regularly. Additionally, it perpetuates formal education as a system of classism and denies opportunities to those who may not have access to the same education pathways as others. These are people who would (or already do) make excellent practitioners within an industry that is almost always running well above its capacity.
* However, in order for a practitioner to recommend the use of a physical restraint in a BSP, it should be mandatory for the practitioner to have completed formal physical restraint training (CPI, Maybo, PART, etc.).
* SP approval? Maybe. If we are considering the need for the SP to provide approval for the practitioner to develop a BSP, does this not indicate the need for better oversight from the NDIS QSC of practitioners who they deem to be suitable under the capability framework?

Having a ‘performance review’ type framework that applies to practitioners would likely be more beneficial than a blanket rule of needing specific qualifications.

Example: if a BSP is assessed as not meeting legislative requirements, is substandard, etc. the SP should have a process of review and mandatory supervision with the practitioner, including education and training.

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Should there be any specific provisions relating to consultation in the development of a BSP, in addition to the requirements in the NDIS Rules?

* Yes. Stating that a participant is non-verbal and cannot express their views on RP should not be deemed sufficient consultation. There should be a requirement to engage with participant in a developmentally appropriate way regarding RP and ascertain information regarding their response to the use of RP through other means of communication.

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

Covered in the above question/answer.

**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. Similar to the model in South Australia (and recently Victoria), certain Environmental Restraints, Mechanical Restraints and the authorisation of one (1) Chemical Restraint should be able to be actioned by APO’s without separate SP authorisation. The level-based authorisation model adopted by South Australia is a great example of an efficient and effective system.

**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)?**

Yes, for practices that are categorised as needing secondary approval (e.g., based on a level-based system of RP categorisation).

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

Benefits:

* Quicker authorisation process
* Less unauthorised reporting
* Instilling a sense of autonomy and diligence within the APOs who are actioning authorisations, thus increasing confidence and competence in their ability to review RP's and advocate for the individual

Risks:

* Lack of oversight may be problematic in stances where APOs are new/inexperienced/unsuitable to fulfil duties
* In some instances, lack of a holistic approach to authorisation
* Inexperienced APOs may seek to authorise practices without due consideration for other competing factors

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

Having experience working across multiple states in Australia, the most efficient authorisation model currently is that of the South Australia.

**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?**

Allowing APOs to consult for other providers would be incredibly beneficial in removing any unconscious bias in the approach to authorisation. The usual safeguarding measures should be employed, e.g., the requirement to disclose any conflict of interest.

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

Yes, there should be an emergency use process.

As is in some states, the ability to authorise a 'grace period' is incredibly beneficial and should be considered. E.g., 2 months beyond plan expiration date. This minimises the likelihood of unauthorised reporting for service providers, and allows additional time for the behaviour support practitioners to ensure an updated plan is finalised prior to authorisation expiry.

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

Covered in a later answer.

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

Yes.

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

This seems unnecessary within the context of NCATs observed function with regard to RP authorisation. I am an APO and have sat on several guardianship hearings, and from my understanding of the current processes, there does not appear to be a benefit in NCAT reviewing the authorisation decision of a restrictive practice. The authorisation of an RP has to be recommended and endorsed by the practitioner developing the plan, then endorsed/authorised by the APO, then (in most cases) approved by an SP/SAO (or as it currently stands in NSW, in consultation with a DCJ Independent Specialist). If there are concerns about the authorisation of a specific restrictive practice, the review should be conducted collaboratively with the relevant persons/providers (senior practitioner, service provider, the appointed guardian, behaviour support practitioner, individual for whom the practice applies, etc). This is a circumstance in which APOs having the function to consult with other providers (as per question 12) would be beneficial.

If there are concerns about the appropriateness of the appointed guardian, then yes, NCAT should be involved and a review should be conducted regarding the suitability of the guardian and their appointed functions.

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

This question is unclear.

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

Yes.

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

Yes, with regard to service provider capacity.

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

Yes, both.

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

Yes.

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

This question is unclear.

**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?**

Yes. In circumstances where there is any concerns of abuse/neglect, or circumstances where there has been any breach of legal guidelines, etc.

**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?**

This question is unclear.

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

This question is unclear.

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

Yes.

**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?**

Sure. All service providers should be implementing restrictive practices within the legislative guidelines, thus ethical providers should not be concerned about which governing body is able to impose sanctions.

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

This question is unclear.

**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?**

If a support worker/provider acts in accordance with an authorisation and in good faith, there should not be any liability on the support worker/provider.

Further consultation on this specific matter is likely to be required to present additional information and encourage a more robust discussion. E.g., if the above circumstance happens, is there any consideration of liability for the SP who provides final authorisation of a practice, or only the provider? If only the provider, why not the SP as well?

**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?**

N/A