Response to the NSW Have Your Say- A legislative Framework to Regulated Restrictive Practices

Respondent/s.	*James Dooley/Ashley Creighton*
Respondent/s Roles	*Behaviour Support Manager/General Manager- Quality and Safeguarding*
Date completed.	*28-2-2025*
CEO Endorsement	*Dr Martin Laverty*
Signature	

Aruma is an organisation dedicated to providing support and services for individuals with disabilities. It focuses on empowering people with disabilities to live fulfilling lives by offering a range of tailored services. These include:

1. Accommodation Services: Providing various housing options, including shared living arrangements and individual accommodations, to ensure a supportive living environment.

2. Community Participation: Encouraging individuals to engage in social and community activities, fostering social inclusion and personal development.

3. Employment Services: Offering programs that assist individuals with disabilities in gaining employment and developing job skills.

4. Children Services: Offering supports and alternative care for children and young people unable to live with their parents.

5. Therapeutic Support: Providing access to various therapeutic services, including occupational therapy, speech therapy, and behaviour support.

Aruma, as an implementing provider, predominantly in Aruma residential accommodation and community services, has a total of 884 behaviour support plans. Of these, 198 involve regulated restrictive practices (RRP) and require authorisation in New South Wales (NSW). Notably, Aruma does not provide direct support to aged care participants or those in out-of-home-care (OOHC) in NSW, and feedback regarding these queries has been sourced from the specialist behaviour support teams.

To support the national authorisation requirements of RRP, Aruma has established a Restrictive Practice Authorisation Team, which includes two Restrictive Practice

Authorisation Coordinators covering our operations in NSW, Australian Capital Territory (ACT), and Queensland (QLD), along with 2.5 full-time equivalent (FTE) Authorised Program Officer (APO) roles supporting the authorisation process in Victoria (VIC). The team is led by a manager, with all activities conducted in collaboration with Behaviour Support Plan authors. These efforts are also coordinated with Aruma operational teams responsible for implementing these supports. The cost of operating the APO model in VIC for Aruma on 2.5 FTE is $300,000.00. This is important to note within context of the proposed changes to the NSW legislative framework, which aims to adopt a similar authorisation model, adding another absorbed cost of operating as a registered provider.

Aruma Therapeutic Support services is a NDIS registered provider that implements specialist behaviour support and clinical author/s of behaviour support plans. Aruma's specialist behaviour support team currently oversees 175 behaviour support plans that endorse the use of regulated restrictive practices nationally. Of these, 106 plans located in NSW, covering a variety of care settings, including NDIS registered providers, aged care, and OOHC.

The specialist behaviour support leadership team at Aruma includes three independent specialists from the Department of Communities and Justice (DCJ), who are subcontracted to the NSW Central Restrictive Practices Team. This partnership aims to assist external providers with the authorisation of regulated restrictive practices. Additionally, Aruma has engaged in two tenders with the Office of the ACT Senior Practitioner and independent clinicians to facilitate the authorisation of behaviour support plans that include regulated restrictive practices under the Senior Practitioner Act 2018.

Aruma has conducted multiple consultations with stakeholders from its specialist behaviour support teams, the restrictive practice authorisation team, and its human rights advisory committee—which includes members with disabilities—to inform this feedback. These consultations referenced the proposed consultation paper, the easy read consultation paper, and feedback from other specialist behaviour support practitioners writing behaviour support plans in states such as QLD, ACT, and VIC. Following this, Aruma conducted a survey based on the outlined consultation questions to facilitate the response presented below.

Aruma also notes specific feedback supplementary to this response from their human rights advisory committee, which includes members with disabilities, is attached as an addendum.

Aruma's Response to the NSW Have Your Say - A Legislative Framework for Regulated Restrictive Practices

Aruma acknowledges that the two proposed authorisation models outlined in the consultation paper—the partially delegated APO model and the two-step APO model—are based on approaches used in other jurisdictions, such as VIC and South Australia (SA). However, these models represent a significant departure from the current consent-based authorisation framework in place in NSW.

Overall, Aruma is broadly supportive of the proposed legislative framework and the establishment of a Senior Practitioner model to safeguard the use of regulated restrictive practices. Nonetheless, we have concerns regarding potential conflicts of interest within the proposed options, specifically the proposed APO model. We suggest alternative approaches and considerations that could enhance independence and oversight within these models.

It is important to highlight that, while these processes are necessary to safeguard vulnerable individuals and uphold their rights, they are also unfunded state-based legislations. The time and cost associated with implementing any processes proposed by the state create pressure on providers, contributing to an already complex fiscal environment where many services are challenged by the current funding model under the NDIS. Aruma, along with other providers, has been advocating for a thorough review of this situation.

Aruma has provided responses to the questions outlined in the consultation paper below:

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

Aruma supports the inclusion of the OOHC setting in the proposed legislative framework. There is a significant overlap between the disability service provision and OOHC. Aruma currently has service agreements to write NDIS funded behaviour support plans for 21 children who reside in OOHC in NSW.

Recent data from the Department of Communities and Justice indicates that, as of June 30, 2024, 49% of young people in residential care were diagnosed with a disability (System Review into Out-of-Home Care, 2024, 3.8.3 National Disability Insurance Scheme (NDIS) and Disability Support, Report to the NSW Government, p. 102). This statistic highlights the increased likelihood of participants qualifying for NDIS funding and necessitates the application of the same rules and registration requirements across both sectors.

Feedback from Aruma's behavior support team indicates that inconsistencies in the definitions of restrictive practices within NSW OOHC, along with separate authorisation requirements, have created confusion and hindered the effective reduction of restrictive practices. One employee noted in the Aruma consultation survey, "*Covering out-of-home care settings could help ensure consistency and coordination between different support systems, such as child protection, family support, and disability services. The NDIS's quality and safeguarding measures could be extended to out-of-home care settings, enhancing protections for vulnerable children and young people*."

Aruma recommends that definitions of these RRP are clarified within any proposed changes, and shares two case study examples which could be evidence contradictions:

- Such as exemptions for non-behavioral psychotropic medications under the NDIS Restrictive Practice and Behaviour Support Rules 2018 which present conflict in NSW OOHC, where medication for the treatment of a physical or mental illness in NSW OOHC is required to be included in a behavior support

plan and consented/authorised by the children principal officer. This has presented scenarios where a behavior support plan written by Aruma acknowledges an exemption under the NDIS rules but also requires the medication to be classified as a chemical restraint requiring approval under OOHC policy.

- Normalised parental strategies in the context of behavior support implementation of registered providers such as "limit setting" screen time for children in a care home could be classified as an environmental restraint. Aruma can provide a detailed case study on request to DCJ to support this review.

Any changes to the framework should align with the NSW Reportable Conduct Scheme and other state-based legislation that protects children and their rights.

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

Aged Care

In addition to disability service provision, Aruma believes the proposed framework should also encompass the aged care setting. This aligns with the Disability Royal Commission's recommendation to extend the Senior Practitioner model to other settings after an initial implementation period. Having different frameworks for the authorisation of restrictive practices in the disability and aged care sectors risks fragmentation and inconsistency in protecting the rights of vulnerable individuals. The specific format of this oversight is not for Aruma to comment on; whether the Senior Practitioner will have regulatory oversight or reporting responsibilities will be a decision for the Department of Communities and Justice (DCJ).

As a specialist behaviour support provider, Aruma currently collaborates with aged care providers that accept participants with NDIS funding and adhere to the NDIS Restrictive Practice and Behaviour Support Rules 2018. This funding requirement has necessitated that these providers seek authorisation.

Education

Aruma, as a behaviour support provider, also acknowledges the inconsistency in the implementation of behaviour support plans that intersect with the education setting. Aruma is aware of instances (and can provide details with consent to DCJ) where the implementation of restrictive practices, as outlined in the NDIS Restrictive Practice and Behaviour Support Rules 2018, has intersected with education. However, since these rules do not apply in educational settings in NSW, there is limited ability to monitor, review, and reduce such practices. Aruma also recognises that in the ACT, the Senior Practitioner Act 2018 provides oversight and regulation of the use of restrictive practices by service providers, including those in the education sector. Aruma also noted that NSW education will at times write their own behaviour support plans in their service setting, separately from the NDIS registered behaviour support practitioner, which is a duplication of resources, and at times inconsistent with recommendations.

Some key points of the ACT Senior Practitioner Act 2018 that Aruma recommends considering for NSW are:

1. The ACT Senior Practitioner Act 2018 applies to service providers delivering educational services to individuals, meaning the Senior Practitioner will have oversight of the use of restrictive practices in schools and other educational settings.

2. All uses of restrictive practices by education providers must be reported to the ACT Senior Practitioner, including practices such as physical restraint, seclusion, and chemical restraint.

3. The ACT Senior Practitioner Act 2018 has the authority to investigate complaints regarding the use of restrictive practices in educational settings and to issue directives to providers concerning positive behaviour support plans and the use of restrictive practices.

4. The ACT Senior Practitioner Act 2018 aims to promote the reduction and elimination of restrictive practices in educational services and to ensure that the rights of students are protected when such practices are employed.

5. The Senior Practitioner will provide education and guidance to schools and other educational providers on alternatives to restrictive practices and best practice approaches.

Aruma believes that the focus on the elimination of restrictive practices and the protection of human rights should emphasise consistency in definitions and the implementation of high-quality behaviour support plans.

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?**

Aruma is concerned about the potential issues and challenges stemming from the existence of different frameworks for the authorisation of restrictive practices in these two settings. Differing requirements, oversight mechanisms, and avenues for review could lead to confusion, add unnecessary complexity, and result in inconsistent outcomes for individuals receiving services across these interconnected environments. A unified framework would help ensure a consistent, rights-based approach to the use of regulated restrictive practices.

Aruma notes that the NDIS Commission has published a comparison of the requirements for aged care and the National Disability Insurance Scheme (NDIS) in its document titled *Comparison of Aged Care Providers and NDIS*, available at [NDIS Commission](https://www.ndiscommission.gov.au/provider-registration/about-registration/residential-aged-care-providers-and-ndis/comparison-aged).

However, Aruma behaviour support team does have participants residing in aged care homes with NDIS funding, where the use of the RRP requires authorisation.

Any application in the aged care setting should consider consent for older adults, particularly those with diminished capacity due to cognitive decline. It should also consider Elder Abuse legislation to ensure congruence and reporting requirements.

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)?

Aruma are not able to comment on the health and justice settings, this consultation should be directed to experts in this area. We would only be advising if processes are in line with the provision of NDIS funded supports within our scope of practice.

Aruma does note the current NSW Restrictive Practice Authorisation Policy 2019 does consider "lawful orders" under section 4.6 stating *"Lawful orders are considered an 'authorised' restrictive practice for the purpose of this policy. However, the practice should be referred to an RPA Panel for the purposes of considering how the requirements are integrated into the participant's behaviour support plan and its implementation."*

Aruma agrees if NDIS funded supports are required to implement a lawful order in the context of a behaviour support plan, there is adequate resourcing and support for the operational team to monitor in the context of behaviour management (such as community treatment orders). Aruma also suggests the behaviour support plan considers how to help the network of implementers use proactive supports, demonstrating the ability to gradually reduce lawful orders to appropriate governing bodies.

There are also circumstances where the lawful order is lapsed, and then the continuity of the same implementation of such practices outlined in the historical lawful order (like a prohibition order around alcohol/internet etc.) requires authorisation and oversight as an RRP. Aruma can provide case studies upon request where implementing providers have maintained practices outlined in a historical lawful order when they have lapsed.

Aruma supports legislation requiring that restrictive practices on NDIS participants in the disability service provision and education be governed by the principles recommended in DRC Recommendation 6.35(b) (see above feedback in previous questions). Embedding these principles in legislation is critical to protecting the rights and dignity of people with disability and driving the reduction and elimination of restrictive practices.

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

Aruma does not have any additional principles to suggest at this time, as the principles outlined in DRC Recommendation 6.35(b) appear comprehensive and well-aligned with upholding the rights of people with disability.

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

Aruma supports the proposed legislative framework prohibiting specific restrictive practices, such as those identified by the Disability Reform Council, across the disability service provision, health, education, and justice settings. Legislating prohibited practices is an important safeguard to prevent the use of the most harmful and unethical interventions. Aruma recognises other states have done so such as at The Senior Practitioner Act 2018 (the Act) and the Victorian Disability Act 2006. Aruma is supportive of prohibition practices such as Practice Alert – High-risk restrictive practices in the NSW care setting.

Question 7: Do you agree that:

- **The framework should use the NDIS definitions of restrictive practices?**
- **The Senior Practitioner should have the power to issue guidelines that clarify how the definitions apply in different situations?**

Aruma agrees that the framework should use the NDIS definitions of restrictive practices, as these are well-established and comprehensive. Aruma also supports the Senior Practitioner having the power to issue guidelines to clarify how the definitions apply in different situations, as this will ensure consistent interpretation and application across service settings. Aruma is aware of examples similar in VIC where the Victorian Senior Practitioner has provided advice/guidelines on off-label medication as an RRP.

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

- **Should the Senior Practitioner have the power to prescribe additional and/or more detailed information for inclusion in the BSP? If so, what information?**
- **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?**
- **Should there be any specific provisions relating to consultation in the development of a BSP, in addition to the requirements in the NDIS Rules?**

Aruma supports the Senior Practitioner having the authority to mandate specific content requirements for behaviour support plans that align with the requirements set forth by the NDIS Quality and Safeguards Commission as shared below:

- Interim Behaviour Support Plan Checklist
- Comprehensive Behaviour Support Plan Checklist

Aruma believes the Senior Practitoner should have the power to mandate content related to behaviour support plan. This would ensure the appropriate authorisation of RRP would only be considered when there is appropriate evidence of imminent risk or harm. Aruma notes the ACT Senior Practitioner Act 2018 Section 12 has a

"*guidelines about behaviour support plans*" for behaviour support plans to include content such as:

  - Author of the plan and professional role.
  - Providers must use the assistance of a person with professional expertise or appropriate experience in relation to positive behaviour support.
  - Evidence that the provider and plan author have consulted appropriately with the person, their family, carers, any guardian or advocate for the person, and any other relevant person.
  - In relation to behaviour(s) of the person that is causing harm to the person or others, a description of the intensity, frequency, and duration of the behaviour(s).
  - In relation to behaviour(s) of the person that is causing harm to the person or others, a description of consequences of the behaviour(s).
  - In relation to behaviour(s) of the person that is causing harm to the person or others, a description of the early warning signs and triggers of the behaviour (s).
- Aruma also notes that the ACT Senior Practitioner Act 2018 mandates the content related to the use of a RRP such as:
  - For routine restrictive practices, adequate environmental supports, preventative strategies, antecedent interventions etc. should be present.
  - Rationale for the use of the restrictive practice which explains why each restrictive practice included in the plan is necessary to prevent harm to the person or others and is the least restrictive approach available.
  - Circumstances in which the restrictive practice is to be used.
  - The procedure for using the restrictive practice, including observations and monitoring that must happen while the restrictive practice is being used.
  - Any other measure that must happen while the restrictive practice is being used that is necessary to ensure the person's proper care and treatment and that the person is safeguarded from abuse, neglect, and exploitation.
  - Schedule of review of the restrictive practice.
  - Strategies for monitoring restrictive practice use.

Aruma agrees that a senior practitioner model would benefit from mandating content to be required to seek authorisation.

In regard to the question, 'should the senior practitioner require a behaviour support practitioner to have certain qualifications,' Aruma believes the existing NDIS Positive Behaviour Support Capability Framework, as overseen by the NDIS Commission, provides the appropriate standards and requirements for behaviour support practitioners and the content of behaviour support plans. Aruma behaviour support teams received notice in February 2025 that NDIS Commission have engaged Flinders University for an external review of the PBS Capability Framework.

Aruma is also currently trailing some "micro-credentialling" courses with Melbourne University for specialist behaviour support which has provided a beneficial insight into developing "capability" within specialist behaviour support registration

Regarding the question, 'should there be any specific provisions relating to consultation in the development of a BSP, in addition to the requirements in the NDIS Rules,' Aruma believes consultation is at the forefront of the authorisation and implementation of RRP.

Aruma has aligned its behaviour support templates to evidence "*intention to use an RRP*" for each participant and provides an "easy read" guide to the intention to utilise a RRP for its participants. In scenarios where the consultation is not able to be conducted due to distress, or limited functional capacity, Aruma will consult a person responsible or caregiver of their informed view of the persons capacity to understand the use of an RRP.

Question 9: **Is there anything else the proposed framework should do to improve the quality of BSPs?**

In addition to the powers outlined in Question 8, Aruma suggests the proposed framework should also require the Senior Practitioner to periodically audit the quality of BSPs, to identify systemic issues and drive continuous improvement.

Question 10: Should APOs be empowered to either:

- **Authorise particular categories of restrictive practices without separate Senior Practitioner authorisation (a partially delegated model). If so, what categories of restrictive practices should be able to be authorised by APOs? Should these be prescribed by legislation, or through class or kind orders?**

- **Provide preliminary approval of restrictive practices, with final authorisation provided in all cases by the Senior Practitioner (a twostep model)?**

Aruma's specialist behaviour support team have concerns regarding the proposed APO model, particularly regarding potential conflicts of interest arising from the APO's employment or consultancy relationship with the provider. While Aruma has successfully developed behaviour support plans with the involvement of APOs under the Disability Services Act 2006 in VIC, it is crucial to recognise that the development of these plans and the authorisation of restrictive practices are fundamentally separate roles that require distinct levels of oversight and accountability.

Currently, Aruma is writing behaviour support plans and submitting them to APOs for approval under the Victorian Disability Services Act 2006. This framework allows the APO to authorise chemical and environmental restraints without direct oversight from the Victorian Senior Practitioner (the APO receives an automatic authorisation letter when submitting the BSP to the VSP), rather the Senior Practitioner will provide random audits of decisions by an APO. Aruma is concerned that this could lead to situations where the interests of the provider inadvertently influence the decisions made by the

APO. Such dynamics can compromise the integrity and independence necessary for making impartial decisions regarding the authorisation of restrictive practices.

Given the increasing number of registered providers, as noted in the recent Australian Government, National Disability Insurance Scheme (NDIS) Commission (2024) *Quarterly Performance Report Q4 2023-24* (pg. 36, Figure 17), which reported 1,849 new providers nationally.
Aruma is concerned with the potential variability in their experience and capability; it is essential to ensure a robust oversight mechanism is in place.

While the current system in VIC, which includes random auditing of APO decisions, is a positive step, it may not be sufficient to mitigate the risks of conflicts of interest that could arise from an APO's dual role.

To address these concerns, Aruma advocates for a two-step model where the APO provides preliminary approval, while the Senior Practitioner retains final authority for all uses of regulated restrictive practices. This structure would enhance accountability and ensure that decisions regarding restrictive practices are made with the highest level of scrutiny and independent oversight, thereby safeguarding the rights and well-being of individuals receiving support.

Additionally, we recommend that APOs hold specific qualifications or adhere to a clear capability framework that delineates their authority in reviewing behaviour support plans. In complex cases, it is crucial that an appropriately qualified individual and/or the senior practitioner is appointed to ensure that any proposed restrictive practice is thoroughly evaluated considering the individual's needs and circumstances. The Senior Practitioner should oversee the review of such complex cases, and Aruma has provided additional information in the following question that could be beneficial.

While the intention behind the APO model is to streamline the authorisation process, it is imperative that any implementation includes strict safeguards to prevent conflicts of interest and uphold the integrity of the authorisation process for restrictive practices.

Aruma also outlines in its own clinical governance framework (Aruma Specialist Behaviour Support Practitioner Procedure 2024 Section 9.10 and 9.11), the level of "capability" of a specialist behaviour support practitioner and the types of regulated restrictive practices that a practitioner can prescribe. These are as outlined below.

> *Core practitioners will need oversight and endorsement from a proficient, advanced, or senior practitioner before endorsing any regulated restrictive practice.*
>
> *9.10. Proficient practitioners can independently endorse:*
>
> *· environmental restraints, and*
>
> *· chemical restraints.*

9.11. A senior or advanced practitioner in Aruma must provide oversight and endorsement for all other regulated restrictive practices, including:

· seclusion,

· physical restraint, and ·

.mechanical restraint.

While this is not a direct correlation of feedback for an authorisation model, Aruma recognises the added complexity of practices such as seclusion, physical restraint, mechanical restraint, and the potential increased risk of injury and harm to a participant or their care team.

This could be an additional consideration for any authorisation model, noting that seclusion, physical restraint and mechanical restraint accounted for 19.5% of RRP in NSW at the end of June 2024, as outlined in the recent Australian Government, National Disability Insurance Scheme (NDIS) Commission. (2024). *Quarterly performance report Q4 2023-24* (pg. 36,).

Jurisdiction	Restrictive practice type	Jan – Mar 2023	Apr – Jun 2023	Jul – Sep 2023	Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024
NSW	Chemical	2,561	2,579	2,617	2,691	2,549	2,633
	Environmental	2,626	2,705	2,810	2,925	2,825	2,887
	Mechanical	673	668	659	682	646	661
	Physical	438	451	493	519	507	539
	Seclusion	173	166	178	177	152	154
	Unknown type	0	0	0	3	0	0

Aruma also notes that medication classified as a chemical restraint also has some safeguards in medical oversight and prescription. This is a beneficial protective factor.

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

As an addition to the APO model, Aruma suggests the proposed framework consider a clinical review model like the ACT, where an independent behaviour support practitioner is engaged by the Senior Practitioner to provide a clinical review and recommendations on the use of restrictive practices. This would help address concerns about conflicts of interest inherent in the APO model already mentioned.

Aruma also notes that the consultation paper references duplication of development of behaviour plans and authorisation as it involves two separate behaviour support practitioners (page 29 of the consultation paper).

Aruma would reference the latest NDIS Commission. (2022). "*Behaviour*

support plan quality public paper" which evidenced the quality of behaviour support plans were consistently poor (see below table). This is something which the RPA Panel process with independent oversight helps mitigate. This paper notes that 51.6% of behaviour support plans evidenced a "weak score" against the Behaviour Support Plan- Quality Evaluation Tool 2 (BSP-QE2), and that an APO does not currently have a requirement to hold certifications or qualifications related to clinical development or review of a behaviour support plan.

The current authorisation model, or the proposed model outlined under the ACT Senior Practitioner Act 2018 does review the quality of behaviour support plans and ensure the content and quality of the plan are sufficient for authorisation.

Total BSP-QEII scores

BSPs considered likely to affect positive change in behaviours of concern and include best practice, score 17 or more out of 24 using the BSP-QEII (within the 'Good' or 'Superior' ranges). From the current results, only 19.7% (n=538) of BSPs scored 17 or more. The national median score of evaluated plans was 12 out of 24. This falls in the 'weak' quality range.

The national scores break down into the following quality categories:

Results of the BSP quality evaluations	Weak	Underdeveloped	Good	Superior
National Scores (N=2,732*)	1410 51.6%	784 28.7%	449 16.4%	89 3.3%

Aruma also notes that NSW is the largest jurisdiction implementing a RRP in the nation. Aruma would suggest if the scaling of the authorisation requirements is a concern in the consultation paper, DCJ should take into consideration having oversight in the proposed senior practitioner model for restrictive practices which might have specific metrics of certain RRP. For example:

1) A chemical restraint that is administered regularly and is consistently overseen or prescribed by the designated medical practitioner, along with the registered provider having clear medication management training and guidelines as specified in the NDIS Practice Standards, may provide adequate safeguards for the authorisation of a chemical restraint. It is important to note that as of the end of June 2024, as outlined in the recent Australian Government, National Disability Insurance Scheme (NDIS) Commission. (2024). *Quarterly performance report Q4 2023-24* (pg. 36,). 42% of the classifications outlined in NSW were chemical restraint, and in these scenarios consistent medical oversight and consultation with an APO, may be sufficient safeguards to seek authorisation from the Senior Practitioner.

2) In scenarios where a restrictive practice presents imminent risk of harm to a participant or care team like a PRN chemical restraint, physical restraint, mechanical restraint or seclusion, a Restrictive Practice Authorisation Panel

may be beneficial. This would entail that the proposed practices are discussed, and the appropriate safeguards are evidenced for each practice. For example, providers are required to evidence:

a. Physical Restraint- Do individual staff members and the implementing provider evidence the appropriate accredited training in physical disengagement, holds and escort?
b. Seclusion- Does the use of Seclusion have:
    i. Means of easy observation
    ii. Maximum time of 15 minutes with 5-minute visual observations.
    iii. Access to bedding, heating/cooling and water?
c. Mechanical Restraint
    i. Is there a clear protocol on how to use the device safely from an allied health professional.

Aruma notes that while all RRP are inherent human rights infringements, these practices present added complexity to someone's quality of life and have increased probability of intersection with criminal infringements and other reporting bodies like NSW police and the Ageing and Disability Commission. Aruma can provide case study examples upon request where the practices have presented increased risk or have intersected with other agencies.

Aruma also recognises that other states can provide some guidance regarding practices that present high risk, such as QLD. In QLD, Seclusion and Containment is required to be written by a behaviour support practitioner from the Positive Behaviour Support and Restrictive Practices Team and a Principal Clinician (state government appointed behaviour support practitioner) as well authorised separately by the Queensland Civil and Administrative Tribunal (QCAT). Such safeguards are beneficial into ensuring the least restrictive principle for practices that present inherent complexity.

Question 12: Should APOs be required to be employed by a single provider? Or should APOs be permitted to be consultants to a number of providers? If so, what safeguards should there be in relation to this?

Aruma employs 2.5 FTE APOs at an annual cost of $300,000 in Victoria. This investment is absorbed by Aruma as part of its operational costs, reflecting the organization's commitment to maintaining quality oversight and support in its services. If Aruma was to adopt this in NSW, where there are another 198 behaviour support plans with RRP, this could increase to cost in excess of $600,000.00.

While Aruma provides feedback on the proposed question below, it recognizes that many registered providers in NSW may not be able to absorb the costs associated with operating a similar APO model. To date, this review of behaviour support plans has sat at an operating cost to DCJ by sub-contracting an Independent Specialist Practitioner to co-convene a Restrictive Practice Panel with a senior manager of the implementing provider as outlined in section 4.5 NSW Restrictive Practice Authorisation Policy 2019. Aruma is concerned how many of its external providers it writes behaviour support plans for could operate under an APO model with their

current resourcing and knowledge of the NDIS Restrictive Practice and Behaviour Support Rule 2018, noting they are quite reliant, in Aruma experience on the current Independent Specialist provided by DCJ to receive authorisation and enhance practice.

Currently, Aruma has employed APOs as a single provider who submits authorisations to the Victorian Senior Practitioner under the Disability Services Act 2006. This arrangement ensures that the APO develops a deep understanding of the specific operational environment of the provider, thereby enhancing their ability to implement behaviour support plans effectively.

If APOs are allowed to consult across multiple providers, it is crucial to establish robust safeguards and oversight to maintain their independence and clinical objectivity. Implementing providers (and their APO) must be aware of various operational resources, such as:

- The NDIS funding plan and Roster of Care (ROC) of the implementing provider, particularly in assessing whether the ROC can support the least restrictive principle when utilizing proposed restrictive practices.
- The capability and training requirements of the implementing provider regarding medication management and administration.
- The training requirements related to seeking authorisation for physical restraints, which necessitate accredited training and oversight. Registered providers who implement physical restraints in NSW are currently required to provide evidence of accredited training in physical restraint escorts and holds. Aruma's accredited training is through the *Crisis Prevention Institute - Safety Intervention*.
- The incident and review mechanisms in place for the ongoing monitoring of proposed restrictive practices.

However, whether an APO is employed as an external consultant, this model could particularly benefit smaller providers in meeting their authorisation requirements. Aruma recommends establishing a mechanism for independent oversight of authorisation decisions made for participants. Additionally, implementing a clear clinical governance framework for APOs would be advantageous, especially in regulated "sub-contracting" scenarios involving smaller market providers.

Moreover, Aruma suggests an audit and registration framework where the decision-making processes of the APO are periodically audited and reviewed. This would ensure consistency in decision-making aligned with the proposed authorisation requirements and the NDIS Restrictive Practice & Behaviour Support Rules 2018.

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

Aruma supports the proposed duration of authorisation and emergency use proposals for restrictive practices. The 12-month maximum duration aligns with NDIS requirements, while the emergency use process provides an appropriate mechanism to address urgent situations before a full authorisation is in place. This

would sit in alignment with the current authorisation requirements outlined in the NSW Restrictive Practice and Authorisation Policy 2019.

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

No, the conditions outlined in Proposal 8 of the consultation paper seem sufficient and consistent with decision making principles of the current authorisation model outlined in the NSW Restrictive Practice and Authorisation Policy 2019.

Question 15: Should authorisation decisions:

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

Aruma supports authorisation decisions being open to both internal review by the Senior Practitioner and external review by NCAT. These independent review mechanisms are critical to ensuring the rights of people subject to restrictive practices are protected.

Aruma draws on its experience at NCAT, noting that there is a delay in tribunal hearings, and inconsistency with NCAT tribunal members experience of disability service provision relating to the definitions of RRP in NSW. Aruma can provide context, for example:

- Safe transport definitions requiring authorisation where NCAT will not be appointed a RRP guardian to consent to the RRP requiring authorisation.
- Chemical restraints where the medical practitioner has exempted the medication, and the behaviour support practitioner has classified it as a chemical restraint. This has resulted in scenarios where Aruma have indefinite unauthorised reporting as NCAT will not appoint a consenting party to the RPP.

Aruma acknowledges the challenges experienced by NCAT achieving timely reviews and findings along with members experienced in complex disabilities.

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 review of a decision not to authorise a restrictive practice?

Aruma believes that the rights to seek a review should not be limited to the person subject to the restrictive practices or to individuals concerned for their welfare. The service provider should also have the right to seek a review of a decision not to authorise a restrictive practice, as they have a legitimate interest in ensuring the safety of both the individual and others.

However, there should be clear guidelines regarding the appropriateness of a service provider seeking to review a decision within the legislative framework. For example, a clinical justification for the need to review a decision should be established to safeguard the person subject to a restrictive practice or the

operational care team. Aruma is concerned that a review system lacking clear guidelines could lead to an increase in the number of reviews required and result in delays in decision-making within the authorisation model.

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

Aruma supports a person having a right to request the service provider review the BSP at any time. This aligns with the principle of supported decision-making and ensures the person's voice remains central to their needs.

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

Aruma supports the Senior Practitioner having both complaints handling and own motion investigation functions. The own motion investigations are particularly important given the power imbalance between providers and people subject to restrictive practices.

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

Aruma agrees the Senior Practitioner should have the proposed powers to respond to the misuse of a restrictive practice, including the ability to direct providers, cancel authorisations, and refer matters to other bodies. These powers are critical to the Senior Practitioner's oversight and enforcement role. This function would be suggested to be related to the authorisation of restrictive practices, and matter around the registration requirements for providers and not meeting those standards should be referred to the NDIS Quality and Safeguards Commission.

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

Aruma believes that the interaction between the Senior Practitioner's complaints and investigation functions and the NDIS Commission's complaints framework should be clearly delineated and complementary. It is important to assess any additional elements that the Commission's powers or actions may not cover (such as consent requirements for use of an RRP). If there are gaps that require "value adding" to what is already in place, it would be prudent for the Office of the Childrens Guardian (OCG) to advocate for the rights of NSW individuals subject to restrictive practices and to improve processes rather than duplicating efforts and creating a two-tiered system for complaints. The Senior Practitioner's role should focus on rectifying specific instances of non-compliance and misuse, while the NDIS Commission retains responsibility for broader provider registration and compliance matters.

Aruma believes that the Senior Practitioner should have the power to share information with a range of bodies, including the NDIS Commission, police, and guardianship/public advocate organisations. Information sharing will be crucial for the Senior Practitioner to effectively identify and respond to issues while ensuring a coordinated approach across the sector.

However, Aruma suggests that privacy requirements, separate from mandatory reporting, should be considered when sharing private information, as outlined in the Privacy Act 1988. The responsibilities under the Privacy Act typically override those of the state and should serve as the foundation for all information sharing. Any additions to or enhancements of these requirements should be clearly documented, and any sharing without consent should be justified by law, explaining the necessity for such action.

Question 22: 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? If not, what additional information should providers be required to report to the Senior Practitioner? How can reporting burden to the Senior Practitioner and the NDIS Commission be minimised?

Aruma believes the proposed means for the Senior Practitioner to have visibility over the use of restrictive practices are generally sufficient, including the required reporting from providers. However, Aruma suggests that the Senior Practitioner should also have the power to conduct random audits of provider records, to further strengthen oversight. Reporting burden should be minimised through alignment with NDIS Commission requirements where possible.

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

Aruma strongly agrees the Senior Practitioner should have the proposed education, guidance, and capacity building functions. These functions are critical to the Senior Practitioner's role in protecting and promoting the rights of people with disability subject to restrictive practices. Aruma notes that the Victorian Senior Practitioner and Aruma have worked together on educative functions of "strengthening the role of the APO" for implementing providers in VIC. Aruma can provide this feedback if requested from their nominated APOs.

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 NDIS legislation and the proposed framework be managed?

Aruma believes the Senior Practitioner should not have the power to impose sanctions for the misuse of restrictive practices. The Senior Practitoner should be able to refer back to the regulator who Aruma is subject to for their registration requirements and riles outlined in the NDIS Restrictive Practice and Behaviour Support Rules 2018. The interaction between the two regulatory frameworks should be clearly outlined to avoid duplication or gaps.

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?

Aruma supports the proposed framework providing a legislated immunity from liability for the use of restrictive practices, where the use was in accordance with an

authorisation and done in good faith. This would provide clarity and certainty for providers implementing authorised restrictive practices in line with the legislation. Aruma would suggest the proposed framework has clear regulation and authorisation requirements of each RRP.

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?

Aruma has no comment.

Conclusion

Aruma is broadly supportive of the proposed NSW legislative framework for regulating restrictive practices, which aims to establish a Senior Practitioner model. However, Aruma has some concerns about potential conflicts of interest in the proposed APO model. Aruma suggests a two-step authorisation process, where the APO provides preliminary approval, and the Senior Practitioner retains final authority.

- Aruma supports the inclusion of the OOHC setting and the aged care setting in the proposed legislative framework to ensure consistent safeguards and oversight.
- Aruma also suggests that the senior practitioner have oversight of the education setting, as there are inconsistencies in the implementation of behaviour support plans that intersect across a child or young person's care team.
- Aruma suggests alternative approaches, such as a clinical review model such as in the ACT, where an independent behaviour support practitioner is engaged by the Senior Practitioner to provide clinical review, recommendations on the use of restrictive practices, and consideration of the classification of such practices requiring an RPA Panel is considered. Aruma recommends that practices like Seclusion, Physical Restraint, and Mechanical Restraint require a clinical review model like an RPA Panel.
- Aruma has concerns regarding the proposed APO model and advocates for a two-step model where the APO provides preliminary approval, and the Senior Practitioner retains final authority.
- Regarding the APO model, Aruma advocates for clear safeguards to maintain the independence and objectivity of the authorisation process, such as periodic audits of APO decisions.
- Aruma also suggests that APOs should have specific qualifications and that the Senior Practitioner should retain final authorisation authority.

Aruma notes they attended the Victorian Senior Practitioners Conference in December 2023. During this conference, indicators were provided to the sector that all Senior Practitioners across each state and territory are committed to working towards a nationally consistent process. This effort aims to ensure collaboration with the NDIS Quality and Safeguards Commission. We hope this approach will emerge from the reviews of processes conducted in all states and territories.