**Organisation**

Caringa

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

Yes. The differences between the NDIS and OOHC RP policies are significant enough that children in OOHC settings sometimes have 2 different behaviour support plans which is redundant work and confusing for implementers.

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

Yes. I believe it should cover the school setting and aged care.

**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?**

With clients in aged care, I feel that there is a lack of reporting and oversight and a tendency to overmedicate.

**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)?**

I think this is a difficult legislation to implement in the health and justice setting.

In the health setting, the client is generally in hospital for an acute condition, and because of this you often see other medications and environmental conditions introduced temporarily. It would be unreasonable and costly to suggest that RPs be changed to reflect a hospital stay.

In a justice setting, if an NDIS client is incarcerated you do not generally have access to them until they are ready to transition back to the community. Therefore it would be unreasonable to suggest that a behaviour practitioner would be able to monitor and report on RPs during the time of incarceration.

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

As per Appendix B: List of prohibited practices endorsed by Disability Reform Council.

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

Yes.

**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, but with an appeals process in place.

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

The senior practitioner should have the power to request additional and more detailed information for inclusion in the behaviour support plan. Strategies should be evidence-based (including citations) and derived from supportive data.

The NDIS should be setting the minimum qualifications of behaviour support practitioners. I believe that there should be minimum qualifications for BSP's of having a minimum bachelor's qualification in a relevant field - e.g. psychology, occupational therapy. The practitioner should also have an NDIS practitioner number.

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

External auditing on the quality of behaviour support plans.

**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)?**

Chemical restraint.

**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.

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

APO's should certainly have minimum qualifications. Should have 5+ years experience working as a registered behaviour support practitioner, have a minimum bachelor's degree in a related field.

**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?**

They should be able to consult to a number of providers, it is not realistic in regional and rural areas otherwise. Conflict of interest declarations should be mandatory.

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

Yes.

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

If a person or guardian withdraws their consent.

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

Yes.

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

Yes.

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

Yes if this also includes the behaviour support practitioner and any other service provider.

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

Yes, and the behaviour support practitioner.

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

Yes.

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

Both.

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

Yes.

**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?**

Person, guardian, behaviour support practitioner, relevant NDIS service provider.

**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?**

Any staff working with a client with restrictive practices should be required to complete behaviour support training every 12 months, or whenever there is a significant change to the person's restrictive practices. It should be mandatory to sign off that you have understood and feel confident with implementing the RP/s.

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

Streamlined policies and processes.

**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?**

This should fall under the NDIS.

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

Streamlining of policies and procedures.

**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.

**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?**

There needs to be a robust appeals process in place if a behaviour practitioner does not agree with the interpretation of the RP legislation and policy for a particular case. It is my experience in the current system that depending on who you get as an independent specialist representing DCJ, you might get a different interpretation, answer, or outcome. If the BSP does not agree with the ruling, there should be the opportunity to put forth an appeal, stating the reasons why, and request that the ruling be revisited by another senior practitioner representative.