**Organisation**

CWC Consulting

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

Yes.

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

Schools have typically been an untouched institution regarding restrictive practices and responding to external regulatory bodies. This new model needs to encapsulate the schooling systems. To go one step further, the new system should also be knocking down the door of private schools.

Furthermore, the roll out needs to go beyond just setting the system up. The senior practitioner department should support statements about what might NOT be regulated restrictive practices that align with community standards.

Concerning schools for example, perimeter gates are locked from 9am to 3pm, with no student allowed to exit freely (e.g. is this a community standard for schools in NSW or something not a standard and possibly an RP). This will help key professionals be more efficient with their time and energy (e.g. more time with the person, etc.).

**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?**

Understanding what a "community standard" is concerning a ‘regulated restrictive practice’ (e.g it is or is not a regulated restrictive practice). There is a lot of inconsistency concerning the interpretation and understanding of regulated restrictive practices. It makes working between settings typically tricky, pushing people to specialise in a specific area.

**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)?**

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)?

It has potential. I do believe the “two-stepped” approach is a good one, with clear criteria for when the SP needs to be engaged (e.g. high-risk restrictive practices, x number of restrictive practices, seclusion, physical restraint, etc).

I think, at times, the sector ‘overdoes it’ concerning safeguarding. For instance, Chemical Restraints are overseen by a psychiatrist, a General practitioner, a pharmacist, a behaviour support practitioner, the person/guardian, etc. All of these individuals are watching and advocating for the person in relation to their medications.

They have positives and negatives. I supervise two practitioners in the Victoria area (Victorian Senior Practitioner), and the areas where the model is poor (negatives); I have summarised these key points below.

Little to no education for APOs (other than generic non-mandatory webinars)

There is no ongoing training/education for APOs. There should be things that they are mandated to do annually (given the ever-changing landscape).

No competency testing of APOs. For example, APOs would benefit from having to do a mandated course and have their knowledge test with a quiz.

The VSP has been firm in their views, often opposing the NQSC. This has been a terrible look and something that practitioners and APOs murmur about behind the scenes. DCJ, moving forward, MUST look closely at systems, legislation and frameworks already in place, building something around what is ALREADY there (A more complimentary approach).

The VSP has been under-resourced, inefficient, and has a very slow body to obtain information/guidance from as a practitioner. At themes, we would have queries responded to 4-6 weeks. Given the safeguarding nature of our role, this is unacceptable. Adequate resources must be installed, and EFFICIENT accessible systems must be implemented. The SP must be accessible and promptly available (e.g. 12hrs a day, 7 days a week).

When the VSP has required to provide proof of authorisation for their RPs, they have often provided it by sending a physical letter out to the APO. This is incredibly inefficient and slow. This process could be streamlined in the portal section (e.g. notification that it has been approved in the DCJ portal or sending of an email).

Lack of consultation when the VSP has been engaged. When the Senior Practitioner is involved, they should meet with the practitioner to discuss the plan and practices (proactive discussions).

VSP requests that plans not be uploaded to the NQSC proda system. This negatively impacts the implementing provider’s ability to report and increases the risk to behaviour support practitioner timeframes for uploading (NQSC enforcement). BSP should be uploaded on completion.

The updated version post-feedback from the SR should be uploaded to PRODA, once they have been completed.

Behaviour support practitioners upload authorisation to the NQSC portal. This process removes accountability from implementing providers. Practitioners should upload plans, and when APOs receive authorisation, they should upload the evidence to the NQSC portal. This helps with accountability of implementing providers.

The VSP enforces that all submissions to them are in the NQSC behaviour support template. This is something I am passionately against. I genuinely believe the NQSC templates are of an incredibly low standard and very ‘sterile’ (not enticing people to use them, etc). These templates are ones I would not use under any circumstance. Some excellent providers have developed fantastic behaviour support plan templates (e.g., embracing the essential sections of a behaviour support plan but adding colour, visuals, and formatting to entice stakeholders to use them more consistently).

And much more!

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

They have positives and negatives. I supervise two practitioners in the Victoria area (Victorian Senior Practitioner), and the areas where the model is poor (negatives); I have summarised these key points below.

Little to no education for APOs (other than generic non-mandatory webinars)

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And much more!

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

Yes, the NQSC have provided a decent list already. Per the previous responses, DCJ MUST review what is already in place and attempt to complement national frameworks. Aim to mesh nicely vs reinvent the wheel.

Furthermore, the list of prohibited practices must be developed into easily accessible resources (clinicians, the person, families, providers, etc). These practices need to be embedded into training, systems, etc.

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

Yes, the NQSC have provided a decent list already. Per the previous responses, DCJ MUST review what is already in place and attempt to complement national frameworks. Aim to mesh nicely vs reinvent the wheel. The NQSC definitions are not perfect; however, they have been in place now (actively implemented) since 2018, so people are familiar with them. Undoubtedly, guidance should come concerning the interpretation and implementation of these definitions.

My only criticism is that “routine” medications (NOT PRN medications), regardless of their purpose, should not be considered a regulated restrictive practice requiring authorisation. This is because they are typically overseen and safeguarded by the person’s psychiatrist, general practitioner, chemist, etc (have their boards, ethics, etc.). These could be captured as impact statements in the person FBA/BAR.

**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 be transparent and have these "guidelines" released to the broader public. Also, SP should issue statements when their view has changed.

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

First and foremost, the Senior Practitioner for NSW MUST have front-line experience in the last 2-3 years as a practitioner (ideally, maintain a connection to front-line service delivery so how). If they don’t have recent experience, they are entirely out of touch with the behaviour support landscape of ‘today’. I have been in the sector for the past 12 years, which has changed so much. If people in key roles are out of touch with how the sector operates, if they had the powers listed below, we will end up in a sector where ‘talent’ will leave the sector (a massive blow for people with disabilities in NSW).

Furthermore, as my earlier criticisms of the Victorian Senior Practitioner model, which is already in place, the DCJ practitioner office will eventually (e.g. 5-10 years from roll out) be at a point where key personnel have not worked clinically for an extended period. This might lead to bureaucrats (or pen pushers) making decisions that are not based on real-world applications (hence my fear of the SP having ‘too many powers’). =

Additional details to BSPs: They can issue additional information (in the form of suggestions); however, the practitioner should be allowed to APPEAL the request if there are appropriate grounds. The joys of the RPA panel process in recent years are the opportunity to justify practices and BSP information in person (have a robust discussion, etc). At times, information is presented in a BSP for a reason. The SP model eliminates this two-way platform (e.g. an IS providing advice in which you can discuss as a group).

Practitioner qualifications: This is a firm no. The behaviour support sector is diverse, which is a positive point (should be celebrated). They are already wheels in motion behind the scenes nationally (NQSC and organisations groups such as “Behaviour Support Practitioners Australia”). DCJ MUST leave this domain in the hands of industry professionals, such as “Behaviour Support Practitioners Australia”. This approach, I feel, oversteps the regulatory frameworks set in place by the NQSC and is unnecessary (not in DCJ’s lane). However, the SP should be working on expectations of quality through the forms of education (e.g. online courses on person-centred collaboration, etc).

Collaboration: This is done fairly well across the sector, with guidance from the NQSC (e.g. resources, statements, checklists, etc).

What role should they play?

They should receive a plan, make a time to speak to the APO and the clinician to discuss the case (following similar frameworks in panels recently).

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

Develop resources designed for specific audiences. For instance, there are a lot of ‘one-size’ fits all resources out there that miss the make. SP could develop resources specifically for families, participants, support workers, clinicians, etc.

There should be guiding resources available for clinicians concerning BSP sections, expectations, etc (including examples). The SP must be accessible for consultation in a prompt manner (e.g. within 48 hours). There should be workshops and possible releases of compliance protocols or sections of plans (highlight the bar/expectation).

**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 - I do agree with this.

* Chemical restraints
* Environmental Restraints (3 or less)
* Mechanical Restraints where there has been an allied health recommendation in the last 18 months (e.g. harness for transport - OT has done a letter, etc).
* Any RP in place for any specific order - mental health order, forensic treatment order, etc.

**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, this makes sense, primarily if APOs are supported with high-quality, mandatory and ongoing training (e.g., a mandatory 12-month training course with competency testing). Various safeguarding points are in play (clinicians, families, support coordinators, planners, etc). Furthermore, the SP needs to be able to review and respond promptly (e.g. within 10 business days).

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

No system is perfect, I do think this system could work if the following points were considered:

* The model being pitched is what is happening down in Victoria. Like any of the authorisation models, they have positives and negatives. I provide supervision to two practitioners in the Victoria area (Victorian Senior Practitioner), and the areas where the model is poor (negatives):
* Little to no education for APOs (other than generic non-mandatory webinars)
* There is no ongoing training/education for APOs. There should be things that they are mandated to do annually (given the ever-changing landscape).
* No competency testing of APOs. For example, APOs would benefit from having to do a mandated course and have their knowledge test with a quiz.

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

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

I would suggest that the APO, the clinician, the implementing manager, and the person (plan nominees) should be made to have a formal meeting about the proposed RPs. The discussion should be documented, using a template/checklist provided by DCJ (e.g. similar to the IS one). The outcome should be documented and used as evidence.

**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?**

An APO with the provider set-up is ideal. They are likely to know the person, know the environment, know the system, etc. However, for smaller providers (e.g., in size or conflicts of interest), they should be able to access an external consultation (e.g., DCJ providing access to someone if a criteria is met).

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

I do not agree with all of the points list above, but I do agree with most of them.

Proposal 6: Yes, no issues. It is already occurring in the current RPA panel model. However, formal review dates and processes would work well (e.g. for high-risk practices).

Proposal 7: No, this creates an extra task in a crisis. NQSC already imposes a safeguarding mechanism of developing an IBSP in 1 month (enforceable by a fine). I strongly suggest working with systems and processes currently in place.

Proposal 8: Yes, these points are already being implemented within the current model. As stated in previous responses, there MUST be an avenue for appeal, as to there might be a ‘real world’ situation at hand.

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

Nothing I can think of*.*

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

Kind of yes - The SP should be notified and then the SP should connect with the practitioner, APO and the client to discuss the matter. It is a waste of taste payers' resources to escalate immediately. Aim to resolve it collaboratively.

Also, this process would be slower, decreasing safeguarding efforts. Please don't forget there is a mechanism through the NQSC for reportable events.

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

Yes - it makes sense for these systems to be connected.

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

No. People's stakeholders change over time (e.g. a 60 year old client with a disability might have no living family left, but 2-3 staff member's who care about them and who have worked with the for several years.

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

Absolutely! With recommendations and reasons. Transparency is critical. Transparency allows for more appropriate and efficient use of taxpayer’s resources (as well as safeguarding).

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

Yes! This, in theory, should already be happening. Also, several ‘compliance’ sections of the BSP must be addressed to satisfy the national legislation (avoiding an enforceable offence by the NQSC).

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

No, this is a duplication of taxpayers' resources. The NDIS Quality Safeguarding Commission has a team of more than 500 staff (doubled in the last 12 months). This has been to help keep up with reportable incidents, which include misused RPs, use of unauthorised RPs, etc. If the SP is concerned, they should report the matter the NQSC, like everyone does (use the mechanism already in place). This makes things CLEARER and less grey (e.g. who to notify, when, etc.). Finally, if a concern is of police involvement level, I would expect that the SP should notify them using the relevant channels.

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

No. They should not authorise them, remove the authorisation, provide guidance on the next steps and report through the relevant networks (e.g., NQSC reportable incident, police, etc).

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

They should be notified, IF it is related to an RP (maybe by the NQSC or the APO as a mandatory measure.

**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?**

* NCAT
* NDIS
* NQSC
* Police

**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?**

If a Comprehensive Behaviour Support Plan has been done well, the FBA (Functional Behaviour Assessment) should include the most recent summaries of RP usage. This is MORE than enough evidence to get things across the line.

Providers are reporting monthly usages on the NQSC portal, this information can EASILY be exported into a spreadsheet at the end of the service, this can be a minor checklist list item for authorisation (if needed...). We quickly forget that practitioners, nominees, coworkers and several other stakeholders work hard to safeguard the person as much as possible.

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

Avoiding duplication of services. Use systems and frameworks already in place. Don’t reinvent the wheel. The industry is already administration-heavy, taking away from positive outcomes for people with disabilities (e.g. eating into funding that could be utilised supporting the development of new skills, etc).

NQSC - reporting monthly, uploading, reportable incidents, incident investigations, etc.

DCJ - JUST authorisation - Yes/No => ethically ok, evidence to support need, less restrictive option, being used for the least amount of time, responding to proportionate risk.

In this proposal so far, you can already tell that DCJ are attempting to ‘bite off’ more than what they can chew. They need to understand what is in play and currently being used and NOT forget their role (they aren’t the NQSC or the NDIS).

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

This piece of the project, I challenge, is more important than getting the authorisation process right. All governing bodies to date have missed the mark concerning education content. There needs to be a big focus on releasing tailored content toward specific audiences (e.g. families, participants, clinicians, support workers, APOs, etc). We need to get away from this “one-size-fits-all” approach and spend time developing tailored resources to deliver critical messages more effectively.

Detailed resources (e.g., policies/procedures for practitioners) must cover the relevant information and then apply the theory points in real-world scenarios. Resources tailored to families should address everyday things they are concerned about (e.g. the process in a nutshell, time frames, their role, complaints/review) and avoid pouring in

More than what they need.

Finally, for critical resources, there needs to be a multipronged approach concerning releasing multi-media forms (e.g. videos, interactive resources, flow charts, detailed documents, etc.).

**Question 24a: Should the Senior Practitioner have the power to impose sanctions for the misuse of restrictive practices, or are existing sanctions for misuse of restrictive practices sufficient?**

No, this is a duplication of taxpayers' resources. The NDIS Quality Safeguarding Commission has a team of more than 500 staff (doubled in the last 12 months). This has been to help keep up with reportable incidents, which include misused RPs, use of unauthorised RPs, etc. If the SP is concerned, they should report the matter the NQSC, like everyone does (use the mechanism already in place). This makes things CLEARER and less grey (e.g. who to notify, when, etc.). Finally, if a concern is of police involvement level, I would expect that the SP should notify them using the relevant channels.

In summary - why reinvent the wheel… There are mechanisms in place already.

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

I am not sure. Use the mechanisms and frameworks already in place (e.g. the NQSC have several mechanisms that can be better utilised). Reach out to them and see how they can accommodate DCJ. For instance, they might be able to give the SP access to the data base of PRODA BSP submissions for them to check usage, uploads, etc.

**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, I think this is common sense. Every situation is different.

**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?**

I would say LESS functions, based on what was proposed. The proposal so far has the SP authorising RPs, regulating who can be a behaviour support clinician, investigating incidents, imposing sections to be written on plans, etc. Don't lose sight of the SP's role, which is to authorise regulated restrictive practices (guidance around authorisation) and to educate ALL stakeholders. Furthermore, avoid duplicating services and use frameworks already in place (E.g. the NQSC reportable incident process). Moreover, the SP (or sub-teams below the SP) must be hired from the industry with recent experience. If this is not done, the system will be mismatched from the reality of today’s complex sector.

I have worked in the sector for 12 years and run my own behaviour support company. I would be very happy to be consulted going forward.