**Name**

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**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?**

No.

**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?**

Given I work in paediatrics I can't comment on this.

**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 but there needs to be a more considered understanding of the importance of safety.

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

There are two issues I have:

1. The document fails to address the issue of safety. The reason that restrictive practises are initiated is typically to maintain safety both for the person involved and for their carers. Safety is paramount and there is a need for restrictive practise policy to be flexible enough and assessed quickly enough to provide safe care. There are situations where delay due to restrictive practise policy are being applied where it is clearly not in the interest of the person involved. For example, I have a family of a child with severe developmental disability who, if given the change would eat his own faeces, being asked to provide a restrictive practise document supporting the use of a one piece garment to stop him doing this, despite the clear risk to health. I have seen multiple cases where children have been denied access to NDIS facilities because of delays in getting documentation to allow compliance with restrictive requirements.

2. Mental Health - a lot of young adults with intellectual disability have mental health disorders which are not readily diagnosed according to current criteria. Moreover the availability of disability skilled psychiatrists is limited meaning that care is often provided by paediatricians. Behaviours of concern are often a manifestation of untreated mental health problems and their treatment with appropriate medication frequently results in greater well being on the part of the person being treated and a decrease in these behaviours. The statement needs to make it clear that medication being used to treat mental health disorders is exempt from this provision.

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

I think legislation should prohibit dangerous physical restraint, but there are some situations where physical restraint is essential for treatment.

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

No - in terms of environmental restraints, this is poorly defined and should be clarified further. eg Limiting access to a kitchen area where some intellectually children could injure themselves should not fall under the definition of restrictive practise.

**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.

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

Unequivocally the BSP should have qualifications, particularly if they are developing a plan for restrictive practice. Behavioural Support Practitioners should be required to consult with clinicians involved in care prior to putting together a plan.

**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.

There needs to be the capacity for a rapid response for questions that relate to safety.

**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 but I think for efficiency there should be some cases which they clearly can sign off on and don't require SP approval.

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

The risk is too much work being sent to the Senior Practitioner and a lack of efficiency.

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

Yes. Allowing APOs to sign off in clearly defined areas and then the SP signing off more complex issues.

**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 employed by the government, this a government regulatory function and the thought that private providers would do this comes with significant risks.

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

No there are situations where problems are indefinite and to have a 12 month limit for a life long problems is not practical. There should be a category for at least 5-10 years. Emergency use is critical.

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

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?**

One of the challenges that I have is the requirement for documentation of drugs that are being used to treat mental health problems being caught up in restrictive practise legislation. Given the limited number of medical practitioners who work in this area and the very few qualified psychiatrists, the documentation demands are considerable and act as a disincentive to treat people appropriately. Moreover the NDIS requirements for documentation are onerous and it is not likely they will be able to be met on an ongoing basis.