**Organisation**

Hunter Primary Care

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

Yes, because individuals in these settings are particularly vulnerable to harm from unregulated practices. Including these settings creates a uniform approach, reduces uncertainty, and upholds human rights. However, there are challenges such as potential overlaps with existing frameworks (already occurs), extra administrative work, and the need for clear definitions and principles that align with current laws. Training and gradual implementation will help manage these changes.

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

Yes, it should cover any setting where restrictive practices are used, including health, education, aged care, and justice. A common standard across these areas will provide clarity for service providers and ensure consistent principles are applied. This would improve safety, accountability, and effectiveness across sectors. At the same time, the framework should be adaptable to the unique needs of each sector, with input from stakeholders, to avoid overburdening or losing focus.

Please note that he NDIS model is currently overly complex compared to other models. Simplifying the NDIS legislative and compliance frameworks would improve understanding and uptake among providers and practitioners. A simpler, more intuitive system would minimise errors and misinterpretations, contributing to more consistent and effective use of restrictive practices across all settings and allowing staff to move seamlessly between care environments.

**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?**

Having different frameworks leads to inconsistency, confusion, and unequal protection for clients in multiple settings and those transitioning. Those receiving care in various environments may not get the same level of support, and practitioners as well as providers often struggle to navigate conflicting rules, increasing the risk of mistakes and non-compliance.

**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 as this is focused on necessity, least restrictive alternatives, human rights, oversight. But there is a risk of non compliance due to complexity. There is a need for much greater extensive training for BSPs and providers and clearer guidelines for application.

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

* Trauma informed care
* Cultural sensitivity
* Individual dignity / autonomy vs duty of care
* Least restrictive alternatives

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

Prohibition of prolonged physical restraint and seclusion is advocated, with a clear position against their use in most circumstances. However, a more regulated approach to chemical restraint is necessary, rather than an outright prohibition, to ensure its appropriate use and oversight and considering the fact NDIS does not regulate the medical profession.

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

Yes, but the definitions provided in the NDIS framework should be completely overhauled to ensure clarity and consistency. This will help prevent misinterpretation and misuse, and ensure that practitioners and providers fully understand how to apply these definitions in different situations.

**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?**

This could put additional pressure on practitioners, especially if Senior Practitioners aren’t easily accessible or able to offer real-world interpretations quickly. It also risks inconsistent application of guidelines. Clear, responsive support like hotlines, emails with a 48-hour response time, or scheduled consultations is suggested. Senior Practitioners must understand both the theory and the real-world challenges practitioners face, bridging the gap between policy and practical application.

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

Ability to prescribe additional information in a BSP but only within current guidelines/templates and with consideration to barriers e.g. lack of funds. The current BSP templates are generally sufficient, but they should include some mandatory components like medication summaries and chemical restrictive practices identification. Longer reports have increased the burden on practitioners, causing delays and additional costs. Some sections should be identified optional and others as mandatory.

In relation to qualification requirements and approval to prepare a BSP with use of RP: The BSP registration process is effective for accrediting practitioners but could be simplified, particularly the self-assessment process. To ensure integrity and impartiality, the review process should involve an independent third party, which would prevent fraudulent assessments and maintain high standards of practice.

Basic competency requirements should be enforced before a practitioner can prepare a BSP, but rigid qualification barriers should be avoided. The framework should allow multiple pathways to demonstrate competence, including formal education, relevant training, or accumulated experience.

Importantly, practitioners should not be barred from preparing BSPs involving restrictive practices until they reach a certain qualification level, or need to seek approval prior to allocation. This is because many referrals do not initially identify restrictive practices as necessary, but these needs often become apparent during assessment or intervention, sometimes very late in the piece. Switching practitioners at this point would disrupt continuity of care, lead to loss of funding, and hinder client progress.

All practitioners should be able to work with restrictive practices, but core practitioners should only recommend RPs under a supervision and endorsement model. This ensures they can be involved in planning and implementing RPs while maintaining appropriate oversight and safeguarding participant wellbeing.

The current system, where a proficient practitioner reviews BSPs, is effective in ensuring no practitioner can independently recommend restrictive practices without the necessary expertise. Additionally, linking more responsibility and higher qualifications/levels with higher funding and wages would help attract and retain skilled professionals, supporting better outcomes for participants.

Current consultation requirements are adequate, but they should consider the willingness and capacity of participants, families, and the multidisciplinary team to engage as well as funding / time limitations. It would also be helpful to include consultations with cultural advisors or interpreters when necessary. Feedback from stakeholders before finalising the BSP can be useful, but clear guidelines and an opt-out option should be provided, as not all stakeholders may want to engage or may lack the expertise to comment effectively.

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

A better, simpler tool for evaluating the quality of BSPs is needed. The BIPQE-II tool, though helpful, is outdated, overly complex, and doesn’t align well with NDIS needs or current templates. There is also a lack of training or support to integrate the measure into practice. Providing a gold standard or de-identified BSP examples could give practitioners a clear baseline to work from.

**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)?**

A partially delegated model could work for low-risk practices, like chemical restrictive practices or time-limited environmental restrictions. These could be specified by legislation or through orders. However, safeguards like independent oversight and conflict-of-interest checks for APOs are necessary. This model could also introduce bias or misuse, and it might slow down authorisation processes due to increased workload and administrative burden.

**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)?**

This doesn’t seem much different from the current interim authorisation process and doesn’t appear to offer significant benefits.

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

Benefits- safeguarding, oversight, accountability (as with independent specialist).

Risks - delays, major overhaul with minimal improvements to current not cost or resource effective.

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

Options:

* Centralised authorisation model: All decisions sit with Senior Practitioner = consistency, impartiality, and adherence to a single standard. But likely to led to delays in approvals and increase workload of Snr Practitioners office.
* Tiered risk-based model: A tiered model could categorise restrictive practices based on their level of risk, with lower-risk practices approved by trained APOs and high-risk practices requiring Senior Practitioner oversight. Preferred option with balance of efficiency and focus.
* Regional authorisation panels: consisting of panel of multidisciplinary experts for collaboration and shared responsibility – but most costly, would need clear structures to manage inconsistencies.
* Technology/AI assisted approval systems: could streamline applications and approvals, incorporating algorithms to flag high-risk cases for additional review. Reduces time spent and admin burden.
* Independent review boards – for contested or complex cases.

**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?**

It’s preferable for APOs to act as consultants across multiple providers rather than being tied to a single provider. This flexibility promotes consistency and allows for expertise to be shared more widely, especially in rural or remote areas. However, safeguarding the participant must be the priority. There should be strict conflict-of-interest management, standardised training, and a comprehensive auditing system to ensure that APOs' decisions are impartial and transparent. These safeguards should ensure the integrity of the system while balancing the need for practical solutions.

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

Yes but - To address issues with interim authorisation processes, there needs to be a clear framework that limits interim approvals to exceptional circumstances only, such as when a participant’s situation is changing rapidly and a full C-PBSP is still under development. Instead of allowing repeated interim plans, there should be a system of fixed review periods, where interim plans are either upgraded to full C-PBSPs or stopped after a specified time, preventing the overuse of emergency authorisation.

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

Yes - Demonstrated harm or risk to the participant, significant deviation from the approved BSP (define significant), non-compliance with reporting requirements or ethical standards (some providers are notorious for this always being the case with every client, yet no compliance action and are able to continue to action unauthorised practices. Clear operational definitions are crucial to ensure consistency and prevent misunderstandings, which could lead to non-compliance. Definitions should be comprehensive and specific, outlining what constitutes “significant deviation” and establishing clear benchmarks for non-compliance. This will ensure that practitioners and providers can apply the rules confidently and correctly, minimizing errors or misinterpretation.

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

Yes, but only under specific conditions to prevent misuse or frivolous appeals.

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

No, due to the long delays and limited capacity to handle complex or nuanced cases effectively. To avoid misuse or unnecessary delays, reviewing authorisation decisions should be focused on ensuring that the review process is transparent, efficient, and structured. One potential solution could be to create a centralised review committee that evaluates the need for authorisation reviews in a timely manner. Clear guidelines must be in place to avoid vexatious or unnecessary appeals, and a timeline for decisions should be firmly set to prevent delays in authorisation.

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

All parties - participants, families, and service providers - should have the right to seek a review, but only under specific circumstances.

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

Providers should be allowed to review decisions, as they play a key role in participant welfare and implementation. They may need to provide additional context or evidence, or request clarification on complex issues. However, BSP expertise must be central to decision-making, and there need to be safeguards to prevent the review process from being unnecessarily prolonged or causing tension between providers and participants. Clear timelines, criteria, and documentation requirements should be in place.

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

No, considering funding and resource limitations and potential for frivolous time wasting, but the framework should set clear criteria for when an early review is warranted, such as significant changes in circumstances (e.g., living arrangements, caregivers), new or more severe behaviours, major environmental changes, or a change of provider. This ensures responsive care while considering practical limitations like funding and time constraints.

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

If the Senior Practitioner is to have complaints handling and investigation functions, it’s essential that they play a supportive, educative role to help guide providers toward compliance. Rather than focusing purely on enforcement, the Senior Practitioner should act as a resource, working with providers to rectify issues and prevent further noncompliance. Clear guidelines should be developed for investigating complaints, with an emphasis on transparency, fairness, and collaboration. Investigations should be impartial, and when violations are found, there should be a focus on education and corrective action rather than immediate punitive measures. This approach will build trust and help cultivate a more responsive and supportive environment for participants and providers. The current system risks adopting a "guilty until proven innocent" approach, which could hinder improvement and create fear. PBS principles show that punishment isn't effective, so applying punitive measures against practitioners contradicts the values of PBS and undermines its approach. This proposal risks turning the NDIS into a "policing" body rather than a supportive and educative framework.

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

No, a separate, independent team should handle complaints and investigations to ensure fairness and transparency - with prescribed time frames. The Senior Practitioner should focus on educating providers to help them understand and meet their obligations. If the same team authorises practices and handles complaints, it could lead to biased investigations due to prior decisions. Participants and families might avoid making complaints if they feel the investigation is not impartial. Clear boundaries should be set between the Authorisation and Complaints Handling Teams to maintain trust and accountability.

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

Rather than focusing solely on the interaction with the NDIS complaints framework, the focus should shift to ensuring that the complaints process integrates smoothly with the broader framework while maintaining a focus on education, transparency, and accountability. There should be a clear, streamlined pathway for escalating concerns about restrictive practices, which provides both support for practitioners and clear guidance for providers. This will reduce duplication, alleviate provider and practitioner concerns about the regulatory burden, and ensure that complaints are handled efficiently and effectively. The primary goal is to resolve issues without unnecessary delays or confusion.

**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?**

The Senior Practitioner should be able to share information with the NDIS Commission, relevant government departments (like health, child protection, law enforcement), advocacy and oversight bodies, service providers, and BSPs. Information should only be shared with consent or when necessary for safety, wellbeing, regulatory compliance, or legal reasons, all while adhering to privacy laws.

**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?**

The Senior Practitioner’s visibility over the use of restrictive practices should be focused on providing robust protections for Behaviour Support Practitioners, as well as ensuring educational resources and guidance for practitioners and providers. There should be clear protocols to protect BSPs from undue pressure or penalties, with a greater emphasis on ongoing professional development and support.

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

Reporting systems should be streamlined to minimize administrative burden, focusing more on prevention and education rather than punitive measures. This would ensure that BSPs can carry out their work without undue stress, while still being accountable for their decisions.

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

Yes – very much needed and need far more focus and emphasis placed on this concept. This role is critical to improving sector-wide understanding, compliance, and the reduction of restrictive practices. Education and support must be prioritised over punitive measures to create a culture where providers are equipped to implement best practices rather than operating out of fear of sanctions.

A strong education and guidance framework ensures that behaviour support practitioners, providers, and frontline workers fully understand their obligations, ethical responsibilities, and alternatives to restrictive practices. Many compliance breaches occur not due to wilful neglect but because of misunderstanding, lack of training, or inconsistent guidelines. When practitioners are given proper education and access to resources, they are better positioned to prevent restrictive practices altogether, implement them only when absolutely necessary, and transition away from them as quickly as possible.

In the past, teams like the NSW Behaviour Support Team played a crucial role in providing guidance and troubleshooting complex cases, but with their removal, practitioners now lack direct access to real-time advice and support. Without an educative and proactive compliance model, there is an increased risk of restrictive practices being misused due to lack of knowledge rather than intent. An advisory function within the Senior Practitioner’s role could help bridge this gap, ensuring practitioners have access to expert advice, professional development opportunities, and ongoing training.

To ensure effective education and guidance, the Senior Practitioner should:

* Develop accessible, sector-wide training modules on positive behaviour support, restrictive practice alternatives, legal obligations, and ethical considerations.
* Provide real-time guidance and case consultation services to practitioners navigating complex cases.
* Support providers with clear, practical resources (e.g., decision-making frameworks, plain-language guides, and model BSP templates).
* Collaborate with universities and training institutions to standardise behaviour support education and ensure graduates enter the field with the right competencies.
* Ensure ongoing professional development opportunities so practitioners remain up to date with best practices and legislative requirements.
* Without strong educational and support functions, restrictive practices will continue to be poorly understood and inconsistently applied, creating risks for participants and unnecessary compliance burdens for practitioners.

**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, the Senior Practitioner should not have this power. Combining a practitioner's role with that of an enforcer could create conflicts of interest and lead to inconsistent or disproportionate actions. An independent third-party body should handle sanctions to ensure impartiality and fairness. Existing sanctions are already significant but can sometimes be applied too harshly, deterring practitioners from reporting errors or seeking support. An independent body can take context into account—such as minor mistakes, funding limitations, or systemic issues—rather than applying blanket punitive measures. This approach would encourage a more constructive culture, supporting compliance and improvement without excessive penalties. The current system has led to providers being penalized for issues outside their control, like delays in behaviour support plans, and has made it difficult for practitioners to handle complex cases without fearing unfair sanctions. A fairer, more balanced approach is necessary to encourage compliance without discouraging practitioners from taking on important, complex work.

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

The Senior Practitioner should prioritise education and guidance over punitive measures. Instead of imposing sanctions immediately, there should be clear and consistent opportunities for providers to receive guidance on improving practice before penalties are considered. Recommendations for corrective action, including structured professional development plans, should be the first step. The emphasis should be on continuous improvement, ensuring that practitioners and providers are supported in meeting compliance standards without feeling that punitive actions are the only consequence.

**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?**

Immunity from liability should apply to practitioners who use restrictive practices in accordance with an authorised Behaviour Support Plan (BSP) and with the participant’s wellbeing as the central priority. Immunity should only apply if the restrictive practice is used in a manner that is necessary, proportionate, and aligned with the participant’s individual needs. This would provide clarity on when immunity applies, so practitioners are protected from legal action in cases where they are following appropriate procedures. Clear documentation and evidence of compliance with the BSP must be kept to demonstrate that the use of restrictive practices is justified.

**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?**

To ensure fair compliance, the Senior Practitioner should focus on supporting providers with accessible training, regular feedback, and clear educational resources to help them meet expectations around restrictive practices. Compliance should be based on reasonable expectations rather than harsh penalties. Recommendations for improving practice should focus on consultation, collaboration, and capacity-building rather than immediate sanctions. In cases of non-compliance, clear action plans should be developed to help providers improve their practices in a reasonable time frame, with a focus on helping rather than penalising.