**Organisation**

South Western Sydney Local Health District

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

It should cover OOHC to help give better consistency in the application and governance of positive behaviour support and restrictive practices across related settings. For example:

* Private agencies who deliver statutory out of home care are frequently also NDIS providers.
* There are children in out of home care settings (including statutory) who have disability / are NDIS participants.
* Transitions from highly restrictive OOHC models for vulnerable young people (e.g. the Sherwood program) to the NDIS setting often fail because of the fundamentally different approach to restrictive practices (e.g. highly restrictive to minimally restrictive). An overarching legislative framework could support smoother and more successful transitions to the disability support system.

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

Yes. The legislative framework should cover all NSW Government service settings where other relevant legislation does not apply.

For example, healthcare settings not subject to the Mental Health Act should be covered (e.g. non-gazetted / general hospital wards). People subject to restrictive practices still come to hospital for health treatment and these are often complex and difficult admissions. Health care staff are challenged by translating the behaviour support framework and restrictive practices into the hospital setting. Medications considered chemical restraints under NDIS legislation can be easily prescribed in hospital without positive behaviour support being applied. This then creates barriers to transitioning to the community when the NDIS positive behaviour support framework then needs to be applied from the beginning.

Consistency in approach will improve the care of individuals who receive care and support from multiple different service settings (i.e. disability + out of home care + education + health 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?**

* Transitions between different settings are complicated by needing to completely re-work behaviour support practices when a person moves between aged care, disability and health settings.
* Health care staff who work with people from both settings need to understand and apply two different approaches which causes confusion, duplication and delays to care. Quality of care can be compromised by this confusion. People can spend much longer in hospital as a result. They may need more intensive behaviour support in the community as a result of institutionalisation that occurs from extended stays in an acute healthcare setting.
* Doctors are often unclear about how chemically restraining medications are viewed and implemented in the two different settings.

**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. The legislative framework should cover all NSW Government service settings where other relevant legislation does not apply.

Consistency in approach will improve the care of individuals who receive care and support from multiple different service settings (i.e. disability + out of home care + education + health care).

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

Transitions of care – the legislation should specifically consider how these principles apply when people transition between these settings, as this is where significant risks and gaps appear. For example, a child or young person with disability at school, a person with disability receiving medical care in hospital, a person with disability in custody transferred to a hospital for medical treatment, a person brought into custody who has a disability, a person in supported independent living receiving community nursing treatment in their home.

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

Nil comment.

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

Yes. The definition of restrictive practices should be consistent across settings.

It would be beneficial to have the Senior Practitioner clarify how the consistent definitions apply specifically to different settings and 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?**

It would be beneficial to have the Senior Practitioner clarify how the consistent definitions apply specifically to different settings and situations.

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

* Regulation of qualifications and credentialling – this would be extremely beneficial to improve the quality of behaviour assessment, behaviour intervention support and behaviour support plans. There is currently enormous variation in the quality of behaviour support and plans under the current credentialling process.
* Creation of education and credentials – it may be necessary to create specific micro-qualifications in behaviour intervention support where professional qualifications don’t exist or sufficiently cover behaviour support and restrictive practices.
* Governance and auditing – the Senior Practitioner’s office could be responsible for auditing compliance with the legislative framework. This could be done in a similar way to how the Australian Council on Healthcare Standards audits healthcare settings or the Aged Care Commission audits aged care settings. Using these models as an example is particularly useful given that medication prescription and management (chemical restraint) is part of behaviour support for people with complex needs.
* (Accessible) Communication about behaviour support and restrictive practices – making sure behaviour support and restrictive practices can be understood by people with disability and their support networks. Family members are important partners in care but it’s not appropriate to rely on volunteers and family members to explain complex concepts like use of medication.

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

It should require that a short summary (no more than 4 pages) of the behaviour support strategies and restrictive practices be prepared to support transitions between service settings. Many behaviour support plans are 30+ pages, meaning that the key information can’t be extracted quickly in urgent circumstances / transitions e.g. a person brought to hospital in an ambulance for urgent medical treatment.

**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)?**

It is unclear in the consultation paper if an APO is different from a NDIS approved Behaviour Support Practitioner, Behaviour Support Practitioners are usually not employed by the provider(s) implementing the behaviour support plan. This approach is supported by the NDIA to reduce the risk of fraud and mismanagement. This feedback is given assuming that an APO is not the person’s behaviour support practitioner and is employed by the implementing provider.

Both models are possible. The partially delegated model offers better efficiency, but would need stronger governance of the APOs (i.e. very specific qualifications and oversight). The two step model would possibly require more staff to make sure that authorisation can be done quickly and efficiently.

**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)?**

It is unclear in the consultation paper if an APO is different from a NDIS approved Behaviour Support Practitioner, Behaviour Support Practitioners are usually not employed by the provider(s) implementing the behaviour support plan. This approach is supported by the NDIA to reduce the risk of fraud and mismanagement. This feedback is given assuming that an APO is not the person’s behaviour support practitioner and is employed by the implementing provider.

Both models are possible. The partially delegated model offers better efficiency, but would need stronger governance of the APOs (i.e. very specific qualifications and oversight). The two step model would possibly require more staff to make sure that authorisation can be done quickly and efficiently.

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

It is unclear in the consultation paper if an APO is different from a NDIS approved Behaviour Support Practitioner, Behaviour Support Practitioners are usually not employed by the provider(s) implementing the behaviour support plan. This approach is supported by the NDIA to reduce the risk of fraud and mismanagement. This feedback is

given assuming that an APO is not the person’s behaviour support practitioner and is employed by the implementing provider.

Both models are possible. The partially delegated model offers better efficiency, but would need stronger governance of the APOs (i.e. very specific qualifications and oversight). The two step model would possibly require more staff to make sure that authorisation can be done quickly and efficiently.

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

Nil comment.

**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?**

Could the APOs come from a specific group of providers “commissioned” by the NSW Government? This would allow tighter governance of the workforce. A commissioned workforce of APOs could also work if this legislative framework applies to other settings (e.g. education, health, justice).

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

Yes, with a caveat.

Simply cancelling authorisation of a restrictive practice when a provider fails to provide evidence could have extremely harmful consequences for the person e.g. sudden loss of environmental restraint could mean a person runs onto the road and is hit by a car or is able to access sharps and self-harm; sudden removal of a chemical restraint could mean someone has medication withdrawal symptoms that risk their health and wellbeing, This penalises the person with disability for the action or inaction of the provider(s).There should be a way to compel provision of information without putting the person at risk of harm.

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

Nil comment.

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

Yes, this is reasonable and mirrors other processes of review.

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

Yes, this is reasonable and mirrors other processes of review.

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

It makes sense that any party with a genuine concern for the person’s wellbeing can seek review.

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

Yes, if there is a genuine concern that a person's welfare could be compromised.

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

In principle yes, but this consultation paper seems to misunderstand who creates behaviour support plans under the NDIS model. It appears to assume that behaviour support practitioners are employed by the same providers who implement the behaviour support plan. This is NOT the case. Requesting that a service provider review a BSP actually means requesting that multiple providers review the BSP.

Behaviour support plans are created by a behaviour support practitioner employed by Provider A. Staff who implement the behaviour support plan are employed by Provider B (e.g. personal support staff), Provider C (e.g. day program), Provider D (e.g. community access) etc.

It is important that the proposed legislative framework is based on correct assumptions about how BSPs are created and implemented.

**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. People with disability who are most at risk are likely to be least supported / empowered to make complaints. The Senior Practitioner should be able to initiate investigation on its own motion.

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

Yes.

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

A formal mechanism allowing the free exchange of information between the Senior Practitioner and the NDIS Commission, police and other relevant State/Commonwealth government bodies is needed.

**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 NDIA, NDIS Commission, NDIS Fraud Taskforce, Australian Federal Police, NSW Police, NSW Ageing and Disability Commission, Office of the Children’s Guardian, NSW Trustee and Guardian, NSW Health, a person’s private medical practitioners.

Wherever there are concerns about the welfare and treatment of a person subject to a behaviour support plan and restrictive practices.

**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?**

An information/ data sharing agreement to allow real-time access to/exchange of information between the office of the Senior Practitioner and the NDIS Commission.

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

An information/ data sharing agreement to allow real-time access to/exchange of information between the office of the Senior Practitioner and the NDIS Commission.

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

Yes, with these functions being extended to settings other than disability support if the legislative framework applies to multiple settings.

**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?**

Yes. This is a high risk area where more governance is needed, not less. The legislation could define how the Senior Practitioner would interact with the NDIS Commission and Fraud Taskforce to determine how to proceed with sanctions.

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

Nil comment.

**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?**

Nil comment.

**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?**

Nil comment.