

Disability Inclusion (Restrictive Practices-NDIS) Amendment Bill

a new NDIS Restrictive Practices
Authorisation regime for South Australia



Contents

Contents	2
Executive Summary	2
About the Report	6
Consultation Process	6
Consultation Feedback	8

Executive Summary

This report summarises the key findings from the public consultation held between 15 December 2020 to 29 January 2021 relating to a new National Disability Insurance Scheme (NDIS) restrictive practices authorisation regime for South Australia. The purpose of the consultation was to seek feedback on the final policy direction ahead of the proposed Disability Inclusion (Restrictive Practices-NDIS) Amendment Bill's (the Bill) introduction into Parliament, and to inform the development of regulations and guidelines.

The South Australian Government consulted with people with disability, families, carers, guardians, service providers, the disability sector and other interested parties. Consultation took place through several channels. This included:

- Focus groups and forums
- YourSAy Online discussion
- Social media
- Written submissions.

The South Australian Government would like to thank the agencies that supported the Department of Human Services (DHS) to advise the sector about the consultation.

The consultation was promoted through YourSAy and DHS newsletters, Facebook and Twitter, and through supporting organisations with a reach of over 130,000 people.

Consultation through YourSAy achieved a combined reach of 56,666 people and generated 4,569 visits to the YourSAy webpage to learn more. The YourSAy newsletter outlining the consultation engagement was sent to 81,290 registered YourSAy users over two emails. These emails were opened a total of 31,983 times, giving a large number of people the opportunity to see the engagement at least once. YourSAy promoted the consultation through social media channels Facebook and Twitter, achieving a combined reach of 20,114 accounts. The YourSAy Facebook posts generated 1,344 engagements with 51 reactions, 12 shares and six comments. Eight written responses were submitted to the YourSAy discussion page.

DHS promoted the consultation through multiple channels, including internal and external newsletters and social media. Two advertisements on DHS social media channels reached 23,805 people and generated 927 clicks, 82 likes and 32 shares. DHS received 12 comments on the DHS Facebook page and a total of 27 written submissions.

We would like to thank everybody who took the time to provide feedback. Your contributions are valued.

Key themes identified through the submissions received and targeted consultation include:

- **Consent** – A key theme raised was that people with disability should be consulted or required to consent to the use of restrictive practices. However, views differed between if this should occur through the behaviour support plan development or the authorisation process.

We have listened to the people of South Australia by strengthening the Bill to include the requirement that: ‘the behaviour support plan was prepared in consultation with the prescribed person’. This is consistent with the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 (NDIS Rules) (Section 20 (3) (d) and (4)). The regulations and guidelines will further detail who will be consulted with in the development of the behaviour support plan.

- **Authority to Authorise Restrictive Practices** – No issues were raised by providers regarding the appointment of an authorised program officer to authorise restrictive practices. However, advocates and peaks raised it as a potential conflict of interest.

This is a key component of the authorisation regime, the role of authorisation is separated from the consent, which is part of the Behaviour Support Plan and does not include the provider. This area will be further addressed as part of the development and implementation of the regulations, policy and guidelines which will clearly articulate a quality process in addition to review and appeal mechanisms.

- **Level 1 and Level 2 Terminology** – There were differing views relating to the terminology. Some respondents said all restrictive practices are intrusive, and some called for stronger safeguards for higher risk practices including use of force only to be authorised by the South Australian Civil and Administrative Tribunal (SACAT). Others suggested a matrix approach as some practices are highly intrusive but low risk or low intrusiveness but high risk. Some respondents provided examples of practices that should be included in Level 1 and Level 2. These points will be addressed in the regulations.

- **South Australian Civil and Administrative Tribunal (SACAT)** – Some respondents still did not understand SACAT’s role in the new legislative framework. Further detail on this will be established as part of the regulation development.
- **Training** – Feedback suggested the Senior Authorising Officer should educate and train people with disability, family, carers or guardians in restrictive practices and people with disability should be engaged to support the training of staff/students. This is planned and will be addressed as part of the development of education and training programs to implement the authorisation regime.
- **Scope** – It was thought the authorisation process should encompass non-NDIS participants and providers i.e. schools, hospitals, youth justice.

In South Australia, there is also work occurring across government, being led by the Attorney-General’s Department, to consider the broader restrictive practices agenda, including the disability portfolio. However, the complexity requires a significant timeframe, which is why the disability work has been prioritised. DHS will continue to work with Attorney-General’s Department in the cross-government restrictive practices work in 2021.

- **Skills and Experience** – The majority of respondents stated the Senior Authorising Officer and Authorised Program Officers must be skilled and have significant experience. The feedback indicated the benefit of knowledge of disability services and experience in the field, tertiary education, working knowledge of law and human rights, person-centred and senior level management experience.

DHS will address this feedback in the role description of the Senior Authorising Officer job specification, regulation, policy or guidelines, as appropriate.

- **Senior Authorising Officer** – A few respondents commented on the use of the term Senior Authorising Officer, claiming it was not in line with other states who have a ‘senior practitioner’ and believe that this will set South Australia back.

It is not believed the title will impact the influence of the position and in South Australia, the role differs as they are not the senior practitioner for the state, with the role in other jurisdictions authorising restrictive practices in multiple environments i.e. not only for NDIS providers or the senior practitioner for the NDIS.

Next steps

All feedback from the consultation process was reviewed and some resulted in amendments to the Bill. The other feedback will inform the development of regulations and guidelines, after the introduction of the Bill into Parliament.

Further consultation will occur on the regulations and the guidelines which will provide clarity on the operations of the new legislative framework.

About the Report

This report summarises the key findings from the public consultation process from 15 December 2020 to 29 January 2021 relating to a new NDIS restrictive practices authorisation regime for South Australia.

The purpose of the consultation was to inform the final policy direction ahead of the Bill's introduction to Parliament and will be drawn upon to support the development of regulations and guidelines.

The current process to authorise restrictive practices is through formal guardianship arrangements through SACAT. The South Australian Government is required to implement a new restrictive practices regime to meet the national principles for restrictive practice authorisation (national principles) as a key milestone in the path to national consistency.

Consultation Process

The South Australian Government consultation process was open to everyone including people with disability, families, carers, guardians, service providers, the disability sector, peak bodies, other interested parties and the broader community. Consultation was through several channels, based around the YourSAy online consultation hub as well as:

- Targeted face-to-face focus groups and online forums
- Providing comments **through online discussion** at YourSAy
- Providing a written submission to **DHSSADisabilityReformIGR@sa.gov.au**
- Posting comments to:

Department of Human Services (DHS)
Disability Access and Inclusion
RE: NDIS Restrictive Practices
PO BOX 292
ADELAIDE SA 5000

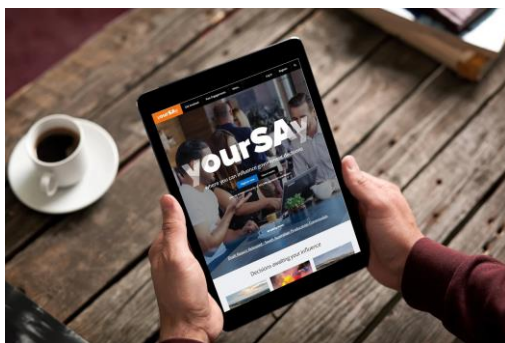
- DHS Social Media



The South Australian Government would like to thank the agencies who supported DHS to advise the sector and the public about the consultation including the NDIS Quality and Safeguards Commission, the National Disability Insurance Agency and National Disability Services – SA Office, which has significant reach across the state and nationally.

We also would like to thank JFA Purple Orange for conducting focus groups on our behalf.

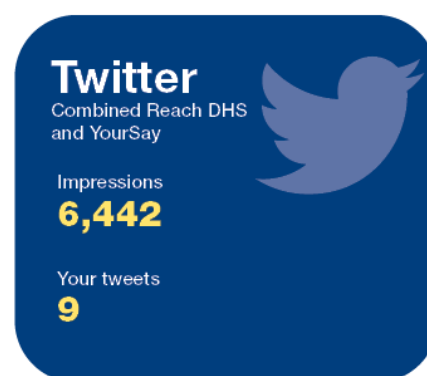
Consultation statistics



The consultation was promoted by YourSAy, whose campaign achieved a combined reach of 56,666 people and generated 4,569 visits to the YourSAy website to learn more.

Facebook and Twitter

YourSAy promoted the consultation through its social media channels Facebook and Twitter achieving a combined reach of 20,114 accounts. Together, the YourSAy and DHS promotions reached 39,335 Facebook accounts and achieved 6,442 impressions on Twitter.



Newsletter



Sent out via email

81,290



Clicks to consultation

278



Email opens

31,983



Consultation website visits

4,569

The YourSAy newsletter

YourSAy promoted the consultation to 81,290 registered YourSAy users, achieving 31,983 email opens and 278 link clicks.

DHS promoted the consultation through multiple channels, including internal and external newsletters and social media. Two advertisements on DHS social media channels reached 23,805 people combined - 10,170 people for the first ad and 13,635 for the second. This generated 927 clicks, 82 likes and 32 shares. DHS received 12 comments on the DHS Facebook page and 27 written submissions. The YourSAy discussion page received eight responses.

Consultation Feedback

The South Australian Government released a Discussion Paper - New NDIS Restrictive Practice Authorisation Process for South Australia, an Overview of amendments to Disability Inclusion Act 2018 fact sheet (including an easy read version) and frequently asked questions to support the consultation process.

The documents were used to inform the disability sector and community about the proposed amendments to the *Disability Inclusion Act 2018* and guide feedback and submissions to the consultation. The Discussion Paper invited people to read the draft Disability Inclusion (Restrictive Practices-NDIS) Amendment Bill 2020, refer to the frequently asked questions and consider several discussion questions.

The following information outlines key points and feedback from the submissions or online discussions.

1 In what circumstances may restrictive practices be needed? What rules and safeguards should be applied? Should the same rules and safeguards apply to all people?

Most respondents agreed that the same rules and safeguards should apply to all people with disability, and a restrictive practice should only be used to ensure the safety of people with disability and protect human rights.

However, in some circumstances some respondents indicated that different safeguards should apply depending on the age of the person with disability, a person's decision-making capacity and a person's culture. In other circumstances consideration needs to be given where a restrictive practice may be used due to the nature of a person's disability and there are no behaviour concerns.

A couple of respondents called for stronger safeguards. For example

'The threshold relating to 'risk of harm', should be increased and the Bill amended to reflect that the risk must be serious or substantial.'

Views between people with disability and parents were similar in saying that they should only be used when the person's 'safety' was at risk, but there were some differences in reasoning.

People with Disability

'Proof for the need to use a restrictive practice should include demonstrating that all other options to respond to the behaviour of concern must have been tried and that no other options but the use of restrictive practices were available. Focus group participants emphasised that trying other options should be a sustained effort and "not just trying on one day for one hour".'

'Also agreed that circumstances where restrictive practices might be needed could include when a person living with disability has requested them. For example, where a person may request the use of some restraints to assist them to control involuntary movements associated with their disability. For example, having bed rails up as they felt safer and may not fall out of bed at night.'

Parents

'People must have boundaries to protect them from harm, even more so people with disability – it is not about the rights of individuals, it's about duty of care, common sense and basic safety.'

People with disability also outlined the authorisation process must strike the right risk balance. For example, some support workers can be very risk averse when authorising restrictive practices because they are scared about their client suffering harm. As a result, unnecessary restrictive practices can be implemented. An approach where risk is analysed and balanced will result in a much better outcome.

Several respondents indicated that these rules should also apply in other non-NDIS service settings such as schools and youth justice, and cover people over 65 and those receiving continuity of care.

2 Are there any other principles that should guide restrictive practices authorisation in South Australia?

The majority of respondents called for the voice of people with disability to be heard in the authorisation process. However, if the person with disability is not able to fully participate in the decision, they are supported by informal arrangements or formal guardianship.

Some respondents thought that the principles could be strengthened to capture the voice of a child or young person with the inclusion of the *United Nations Convention on the Rights of the Child* and the inclusion of culturally appropriate or culturally sensitive considerations in all aspects of the authorisation process.

Some respondents noted that the authorisation process should be clear, fair and consistent with recognition of the diverse circumstances and reasons that restrictive practices are used.

'Duty of care and 'do no harm' principle, considering the short and long-term implications of restrictive practice on the client.'

3 Aside from the agreed national list of prohibited practices, are there any other restrictive practices that should not be allowed?

Most respondents agreed that prohibited practices outlined in the Discussion Paper cover those practices that should not be allowed and that all prohibited practices required national consistency.

However, some respondents indicated that any practice that has the potential to cause harm and/or injury to a person and any practice that would be thought, by the general community, as undignified should be prohibited.

Consideration should also be given to what types of practices should be prohibited in relation to children.

'Prone restraint and floor restraints should not be used at all on children and are potentially dangerous.'

4 *What restrictive practices are less intrusive?*

Most respondents noted that all restrictive practices are intrusive, and it is the impact the practice has on the person that will indicate how intrusive a practice is.

'ALL Restrictive Practices are intrusive regardless of how 'intrusive or not' they may be. More or less intrusive is not necessarily a measure of good / bad or similar. What is more or less intrusive may be based heavily on circumstances. For example, chemical restraint to enable a procedure such as a medical or personal care procedure is much kinder than physically holding the person down but sedating the person as a way of not having to address their needs is unacceptable.'

Others indicated that in general the following were less intrusive:

- Environmental restraints that have safety as their primary purpose such as:
 - Safety locks on gates
 - Safety locks on cupboards and fridges (risks include food allergies, sharps, chemicals or conditions such as Prader-Willi syndrome) but only if risks exist
 - Locks on medication storage cupboards
 - Cot sides on beds, particularly for a person who may be subject to involuntary physical movements from time to time
 - Short term seclusion required to protect others during a violent behavioural outburst.
- Medication (considered to be chemical restraint) administered with the clients' consent should not require authorisation by the state.

5 *What restrictive practices are more intrusive?*

Some respondents indicated, as above, that all restrictive practices are intrusive. However, some indicated the following should be considered as more intrusive types of restrictive practices:

- Chemical restraint where the client does not consent and where the primary purpose of the chemical is to manage behaviour
- Physical and mechanical restraint except in the short term to prevent someone from immediate harm
- Ongoing seclusion
- Detention
- Full 24/7 locked door model
- Line of sight (detention or environmental?)
- Items are locked away 24/7.

6 *How should people participate in the restrictive practice authorisation?*

Respondents considered that the voice of people with disability in the authorisation process was missing, regardless of whether the person was able to fully participate in the decision or their decision making was supported by informal arrangements or formal guardianship.

Some indicated that a person with disability, their family or guardian should also consent to the use of a restrictive practice. However, when consent is given, this differed with some indicating it could be in the development of the behaviour support plan and others in the authorisation process.

People with disability should, wherever possible, attend hearings and they and their advocates/key support network should be given the opportunity to speak/raise issues both before and during the authorisation hearing.

A few also outlined that at the commencement of the process people with disability should be offered an independent advocate (funded by the state) to assist them throughout the process including the authorisation hearing. Hearings should also address the needs of people with limited cognition to rephrase statements so they can be understood by the person. They should also be informal. Providers and behaviour support practitioners should also be afforded the opportunity to speak and provide rationale for the use of the restrictive practice.

7 *Is a tiered approach to authorisation of restrictive practices based on risk and level of intrusiveness, the right approach?*

There were differing views on a tiered approach where some respondents (providers, worker association, peaks) were supportive and others (peaks and advocates) did not support a tiered approach. Others suggested a matrix approach, but still supported some practices to be approved by an Authorised Program Officer.

'If this style of authorisation was to proceed, that the tiers/levels be used not according to the practice but by the identified impact when the restrictive practice is implemented.'

'Yes, as long as the approach applied is consistent and the definitions of risk and intrusiveness match the NDIS behaviour support framework.'

'Preferably a matrix approach where Authorising Officers may be able to authorise restrictive practices that are intrusive but low risk or conversely practices that are not intrusive but high risk (preventing access to internet if content inappropriate).'

8 *What types of practices should not be defined as detention in the regulations? For example: locking the door overnight or maybe during the day.*

Respondents were of the same view that detention is when the primary purpose is to stop or prevent clients leaving premises or part premises (or room) of their own volition.

'If the client is locked in the room or if the use of this room is not voluntary, then this becomes detention.'

Some respondents indicated that practices that are normal/commonly used within the general community should not be considered "detention". These include:

- Locks on house front and back doors at night and during the day (with access to keys for emergencies) for general security purposes
- Locks on support staff rooms/offices to provide for privacy and maintain confidentiality
- Providing a client with unrestricted access to a quiet room or quiet space so they can self-regulate as and when needed.

Other comments included:

'Detention has a continuum of intrusiveness from detention that is against someone's will - prevents someone deliberately placing themselves or others at risk (e.g. leaving home to access illicit drugs in the community) to detention that prevents someone from placing themselves or others at risk without intent (e.g. leaving the home and wandering into traffic due to a lack of road safety skills).'

'The wording such as "order", "detention" and "detained" had a negative impact on one Aboriginal participant and his wellbeing personally and culturally. The connotations of these words made him feel as though he could be "punished" for being "naughty". It was expressed that current and proposed wording was "heavy handed" and made it sound like he was a criminal, and it was a penalty. This particular aspect caused great distress and deep emotion for this participant due to his lived experience and the feeling like he had no choice or control over matters that concern him.'

Other respondents required further clarity particularly around what is considered environmental restraint and seclusion. Where another respondent thought this area could be strengthened.

'This section may be strengthened by recognising the psychological and emotional means of coercion that may be used:

- *When a person may not have intellectual capacity to question or evaluate information about their ability to leave the premises*
- *When a person may be fearful of perceived power and authority due to previous experiences of authoritarianism and institutionalism.'*

9 What skills and experience does an Authorised Program Officer and Senior Authorising Officer (decision makers) need to authorise restrictive practices?

Respondents indicated that Authorised Program Officers should have a degree in an allied health profession, with significant experience in the disability services sector, behaviour support and demonstrated ability to understand and apply restrictive practice regulations appropriately and in line with best practice and human rights.

Respondents indicated that the Senior Authorising Officer should have an appropriate qualification, knowledge and experience in the application of best practice in human right frameworks, behaviour support and restrictive practices in the disability services sector. The Senior Authorising Officer also needs to demonstrate strong leadership skills, experience at a senior management level and the competencies in training and education, and stay updated with best practice and professional development opportunities including improvements in and/or modernised best practice strategies.

Some suggested the skills and experience should be outlined in the legislation.

People with disability stated, *'they need to know what disability is, be patient and just be human.'*

Some respondents outlined an embedded authorisation process was required which includes obtaining appropriate approvals. Some noted that the current process relating to consent has been a pain point; in particular, formal and informal guardianship is confusing. It was

suggested that organisations should have an internal committee that oversees the implementation of restrictive practices within an organisation with reporting responsibilities to Executive.

Other respondents outlined the following as important aspects when considering whether to authorise a restrictive practice:

- All restrictive practices should meet the same conditions regardless of intrusiveness
- Need a streamlined process for emergency restrictive practices linked to the Interim Behaviour Support Plan process for the NDIS Quality and Safeguards Commission
- Minimum conditions should include:
 - a) Description of behaviour that is addressed by the use of the restrictive practice
 - b) Defined risk assessment of the behaviour without the use of the restrictive practice
 - c) Defined risk assessment of the behaviour with the use of the restrictive practice (must be less than without the restrictive practice)
 - d) Inclusion of proactive strategies that are used prior to the behaviour occurring
 - e) Clear instruction for implementing the restrictive practice (similar to emergency/interim response plans) written by a behaviour support practitioner as defined by the NDIS Quality and Safeguards Commission.

'The Authorisation process links closely with the behaviour support planning process. Possibly a matrix of risk and intrusiveness with urgency; the more intrusive practice, the more detail is required for authorisation of an emergency response plan. For example, a provider's Clinical Advisory Group works well in this process because it raises issues that need to be considered and has on occasion suggested less restrictive practices than those proposed by a practitioner.'

'Changes to Interim Behaviour Support Plans and templates are required: conditions, clear guidelines on how to use RP's including proactive strategies beforehand, how to use practices safely, and risk assessment of behaviour versus practice.'

11 What information should decision makers use when deciding whether to authorise the use of a restrictive practice?

Some respondents were satisfied with the requirements stipulated by the NDIS Quality and Safeguards Commission and the *National Disability Insurance Scheme (Behaviour Support and Restrictive Practices) Rules 2018* relating to behaviour support and restrictive practices.

Other respondents considered the following information as important for decision makers to use in deciding whether to authorise the use of a restrictive practice including a sound analysis of:

- Client goals
- Behaviour support plan including behaviour assessment, medical and other reports, including incident reports
- Risk balance between practice and behaviour and risk of not using versus risk of using
- All strategies trialed, including alternative strategies, details of the length of time and how often a strategy has been trialed as well as strategies previously trialed, including previous behaviour support plans
- The number of times a restrictive practice has been used and the circumstances
- Can the restrictive practice be implemented safely in context with other support needs?
- The length of time until review of the restrictive practice is required.

12 *How should the quality and consistency of restrictive practices authorisation decision be monitored?*

Reporting on the use of Restrictive Practices to the Senior Authorising Officer was a consistent message of respondents to support the monitoring role as well as data analysis and identifying trends. This also supports the reduction and elimination of restrictive practices.

Some respondents called for providers to ensure they have robust governance within the organisation, and people with disability called for daily reflection by staff on the use of restrictive practices, as well as workers discussing human rights.

Consideration should also be given to a robust feedback mechanism/system relating to the proposed new roles to measure efficiency. Others suggested the establishment of an effective audit process and outcomes measurement reporting framework, clinical supervision framework and capability framework for officers or accreditation by the NDIS Quality and Safeguards Commission and annual reporting.

13 *Are there any further comments?*

There was a consistent theme relating to education and training, where the role of the Senior Authorising Officer included capacity building and training of people with disability, their families/guardians, support workers and in some cases General Practitioners (GPs) and allied health professionals in restrictive practices.

Education and training are an important element highlighted particularly by people with disability.

‘There needs to be training of staff particularly in a group setting i.e. restricted meal times, being given the same food as others, or not being able to help themselves if they are capable, meals being thrown out if a person arrives at the table late – this felt like

punishment, not having access to their money until everyone in the house was going out together.'

'People with disability should be included in the training of staff – i.e. students visiting or in a classroom.'

'Disengaged and disagreeable clients and support people make it difficult to implement safe and quality supports while meeting legal obligations.'

Some respondents requested clarity about the authorisation timeframes, officers to review in between Senior Authorising Officer longer term and how the authorisation fits in with the NDIS behaviour support plan process.

Clear guidelines outlining what 'is' and 'is not' a restrictive practice including where a person has a health condition and devices for therapeutic or non-behavioural purposes are required.

A person with lived experience, supported by Deaf Australia, proposed a new Restrictive Practice - Communicative Restrictive Practices.

'Children are being deprived of learning sign language over oral techniques and a high percentage suffer severe language deprivation.'

Clarity is required relating to whether a person who may not necessarily have behaviours of concern but may be subject to the use of a restrictive practice due to the determined limitations of 'mental capacity' of a person, as determined by a doctor, and the safety aspects that often come with that. An example of this might be if someone does not understand the difference between hot and cold and the dangers in a kitchen and may have access restricted.

Some respondents raised the following concerns:

- The use of the term Senior Authorising Officer not aligning with other states where the term Senior Practitioner is used
- There being no references to behaviour support plans needing to be current or active
- It is not clearly articulated that restrictive practices should only ever be used as a last resort and evidence of least restrictive means of supporting the person should be provided
- Discourage coercive applications for guardianship or abuse of the guardianship role for the purposes of avoiding or concealing written notices
- The use of consistent language with other legislation; for example, 'revoked' 'ceased'
- Supported decision making not being included

- Powers to search persons and remove their belongings.

Next steps

All feedback from the consultation process has been reviewed. As an outcome of the consultation the State Government amended the Bill to expressly include consultation with “the prescribed person”. This is consistent with the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 (NDIS Rules) (Section 20 (3) (d) and (4)). The regulations and guidelines will further detail who will be consulted with in the development of the behaviour support plan.

All other feedback will inform the development of regulations and guidelines, after the introduction of the proposed Bill to Parliament.

Further consultation will occur on the regulations, with these and the guidelines to be developed providing clarity on the operations of the new legislative framework.

Key terms

Combined reach

The sum of people or accounts reached through a group of communication channels or promotional activities.

Reach

The number of people or accounts who had an opportunity to see (exposed to) the consultation (per communication channel).

Impressions (Twitter)

The number of people or accounts who had an opportunity to see (exposed to) a post promoting the consultation.

Engagement (Facebook)

The number of interactions with a relevant post, for example by commenting on, liking, sharing or clicking upon particular elements of the post.

Engagement rate (Facebook)

The percentage of people who actively engaged with the post out of the total people reached. This includes users' comments, shares, likes and links clicks. According to Rival IQ, the median engagement rate is 0.09%.

Reactions (Facebook)

The number of reaction interactions with a relevant post. This is one of the six animated emotions, including 'like'.

Unique views (website)

Counts a page view once even if it was viewed multiple times within a single session.

Views (website)

The total number of page views within the consultation.

