



Purple Orange

**Report on focus group consultations
regarding the draft *Disability Inclusion
(Restrictive Practices—NDIS)
Regulations 2021***

Final Report for the Department of Human Services

July 2021

About JFA Purple Orange

JFA Purple Orange is an independent, social profit organisation that undertakes systemic policy analysis and advocacy across a range of issues affecting people living with disability and their families.

Our work is characterised by co-design and co-production and includes hosting a number of user-led initiatives.

Much of our work involves connecting people living with disability to good information and to each other. We also work extensively in multi-stakeholder consultation and collaboration, especially around policy and practice that helps ensure people living with disability are welcomed as valued members of the mainstream community.

Our work is informed by a model called *Citizenhood*.

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1. Executive summary

This report describes findings from two focus groups held in June 2021 organised by JFA Purple Orange at the request of the Department of Human Services. The focus groups comprised people living with disability, family members and carers, and support workers. A metro focus group was held in Adelaide and a regional focus group was held in a regional location. The purpose of the focus groups was to seek the views of participants about the draft *Disability Inclusion (Restrictive Practices—NDIS) Regulations 2021*.

Participants in both focus groups agreed that the person subject to the use of restrictive practices should be placed at the centre of the regulations with their individuality and human rights recognised. Participants also wanted the regulations to reflect and proactively counter the broader context in which restrictive practices are used, including that:

- People living with disability and carers are often ignored and not heard
- There is currently widespread overuse and misuse of restrictive practices
- Access to behaviour support specialists is limited, especially in regional areas, therefore, even if a plan is developed, it is typically of poor quality and little capacity building actually happens as a result
- The overall quality of the disability sector workforce is currently low, especially in regional areas where worker shortages persist

Level 1 and 2 restrictive practices

Participants in both groups concurred that the introduction of levels created complexity and ambiguity that would require an investment in education and awareness to be implemented effectively. The regional group emphasised that the categorisation of practices relegated the important considerations of the individual and the situation. The metro focus group indicated they felt that seclusion and environmental restraints were high impact while the regional group highlighted the increased level of risks associated with chemical restraints, particularly those given on an 'as needed' basis.

Prohibited practices

Both focus groups quickly shifted the discussion of prohibited practices to the need to reduce and eliminate all uses of restrictive practices on people living with disability through a greater emphasis on, and training for, alternative approaches.

Risk of harm

Given the prevalence of the use of restrictive practices, participants in both focus groups agreed that 'risk of harm' in the regulations is defined too broadly and may inadvertently allow inappropriate interpretations. Both groups recognised the need to protect people, but felt the term should be more clearly defined. There was concern among metro focus group participants about restrictive practices used on NDIS participants in other settings.

Notifying person subject to restrictive practices

Both focus groups were adamant that the person should be placed at the centre of the regulations. Participants agreed that the person should be involved in the authorisation process to the greatest extent possible at every stage of the process and that this needs to include the provision of information, genuine consultation, and supported decision making approaches. To facilitate this, a person should receive support and advocacy assistance from an independent person. Notifications are essential in the early stages, but a person should have choice as to the frequency of ongoing notifications.

Reporting requirements

Both focus groups agree that authorisations by APOs should be reported promptly. For ongoing use, the metro focus group feared that lengthy reporting timeframes could allow problems to be overlooked for extended periods and favoured shorter timeframes. They also discussed technological solutions to streamline reporting. The regional focus group was more relaxed about reporting requirements.

Qualifications and experience of SAO and APOs

Both focus groups favoured values and lived experiences over formal qualifications for the Senior Authorising Officer (SAO) and the Authorised Program Officers (APOs) and agreed

that requirements should not be defined too narrowly in the regulations. The metro focus group was concerned about the conflict of interest inherent in the APO roles and indicated that education and training may go some way to mitigating this. The regional focus group was more sceptical about the role of the SAO and their sense of distance and remoteness from the restrictive practices arrangements and associated authorising roles was palpable.

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2. List of recommendations

Recommendation 1

That the South Australian government invest in education and awareness about restrictive practices authorisations prior to implementation, and on an ongoing basis thereafter, to ensure that the new arrangements are well understood by all stakeholders. It should provide clear guidance on the categories of practices that constitute Level 1 and 2 restrictive practices, including practical examples, and this guidance should be tailored and accessible to people living with disability and their families, guardians and carers, as well as the disability sector as a whole.

Recommendation 2

That the South Australian government consider elevating all chemical restraints to Level 2, or, at a minimum, chemical restraints used on an 'as needed' basis should be added as a category of chemical restraints within Level 2.

Recommendation 3

That the South Australian government and the NDIS Quality and Safeguarding Commission address the myriad of workforce issues affecting the disability sector that result in an increase in the use of restrictive practices on NDIS participants in South Australia.

Recommendation 4

That the boundaries of the concept of "risk of harm" be more clearly defined in the regulations to reduce the potential for interpretations to be applied that are too broad or overly risk adverse, to give increased weight to the proportionality of responses, and to ensure that dignity of risk is upheld.

Recommendation 5

That the South Australian government prioritise its review – which the Minister for Human Services has indicated is underway – of restrictive practices across all settings and work to build greater consistency and protections for all South Australians, particularly where disability and mental health intersects with other settings, such as law enforcement and correctional services.

Recommendation 6

That the person living with disability be placed at the centre of the regulations with supported decision-making approaches made a key feature of the authorisation arrangements. Accordingly, the regulations should require that the person subject to restraint, or when appropriate a support person of their choice, receives timely and fully transparent notifications of both the authorisation process and the use of restrictive practices. For ongoing use, the person subject to restraint or their support person should be able to request how and when they are notified and to have this included as a condition of an authorisation.

Recommendation 7

That reporting requirements for each Level 1 authorisation be streamlined through the implementation of a digital portal or online system with integrated functionality between providers and the SAO. This could include a function to automatically lodge an authorisation granted by an APO to the SAO as it is finalised in the provider setting. In the absence of such a system, each authorisation should be reported to the SAO as soon as practicable after being granted by an APO.

Recommendation 8

That providers report their ongoing use of restrictive practices through a streamlined digital portal or online system according to a standard timeframe that should be no longer than one month. When more frequent reporting is warranted in a particular case, the SAO or an APO should have the option to attach a condition to an authorisation to create a non-standard reporting timeframe under that authorisation.

Recommendation 9

That requirements for the qualifications and experience of the SAO and APOs be broad to ensure a wide pool of potential appointees, however the regulations should indicate a preference for lived experience.

Recommendation 10

That the regulations require that the selection panel and the decision making processes for the appointment of the SAO include at least two people living with disability.

Recommendation 11

That the regulations require that the SAO provides mandatory training to APOs prior to authorising them to authorise Level 1 restrictive practices in a provider setting. This training should include the first-hand lived experiences of people subject to restrictive practices.

Recommendation 12

That the South Australian government make provision for the office of the SAO to have a meaningful presence in rural and regional South Australia to ensure the office provides support and is available to those communities on an equal basis with Adelaide. The SAO should conduct genuine consultations with rural and regional stakeholders on a regular basis to bridge the current gap between these communities and the governance of disability services and supports.

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3. Background

In May 2021, the South Australian parliament passed the *Disability Inclusion (Restrictive Practices – NDIS) Amendment Bill 2021*. The Bill changes the way that the use of restrictive practices by NDIS providers on NDIS participants are authorised in South Australia. The new arrangements require the implementation of regulations and guidelines.

In June 2021, the South Australian government conducted a consultation on its draft *Disability Inclusion (Restrictive Practices—NDIS) Regulations 2021*, which will be implemented under the amended *Disability Inclusion Act 2018*. As part of this consultation process, the Department of Human Services commissioned JFA Purple Orange to conduct two focus groups and to report back on the findings of the focus groups. This report contains those findings and recommendations.

4. Methodology

JFA Purple Orange utilised a targeted recruitment approach in order to engage people living with disability, family members and support workers in metropolitan Adelaide and regional South Australia in order to participate in two focus groups for this consultation.

4.1. Ethical considerations

This project was designed in accordance with the JFA Purple Orange Ethics Protocol. All participants gave informed consent prior to taking part in the focus groups. The research team provided all participants with information about how the focus groups would be conducted and provided them with background information about the proposed reforms prior to the focus groups.

All data captured during focus group sessions was stored securely in a password-protected electronic file within the JFA Purple Orange office. Data was stored in a de-identified and confidential format, with only the research team having access to the data.

4.2. Focus groups

The focus groups comprised people living with disability, family members and carers, and support workers. The metro focus group comprised six participants and was held in-person at JFA Purple Orange's office in Unley, South Australia. The regional focus group comprised 11 participants and was held in-person at a regional location in South Australia. A mixture of disability types were included across both focus groups, including representation from people living with physical, sensory, intellectual, acquired and sensory disability types.

Both focus groups lasted for approximately 90 minutes and were led by two facilitators, one of whom had lived experience of disability. Both facilitators held current police checks and disability-related employment screening clearances. All accessibility requirements were planned for and met by the researchers. All data was collected in accordance with the JFA Purple Orange Research Ethics Protocol and has been stored confidentially in a deidentified format.

The purpose of the focus groups was clearly outlined to participants via phone calls and emails prior to the focus groups and a verbal statement supplied by the researchers at the

commencement of each focus group. The same questions were discussed in both focus groups. The questions were based on those in the 'Restrictive Practices Background Paper – Regulations' issued by the Department of Human Services and the feedback survey on the South Australia government's 'yourSAY' consultation webpage.

All participants were offered an honorarium for their time.

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5. Discussion of findings

This section describes the issues discussed by the focus groups in response to the following topics and questions:

Level 1 and 2 restrictive practices

1. Level 1 restrictive practices are lower impact and approved by Authorised Program Officers working for providers. Level 2 are higher impact and approved by the government's Senior Authorising Officer. What practices or situations should be Level 2?
2. Are there priority groups for whom there should be more protections than for others?
3. To use a restrictive practice there must be a "risk of harm". How should it be defined?

Prohibited practices

4. What kinds of practices should be banned?
5. Is there equipment or other items that should be banned from use?
6. Is there anything that should be banned only for some groups?

Notifications

7. When and how should the person living with disability and/or their family or support person be notified of restrictive practices? What information should they be given?

Reporting

8. When should Authorised Program Officers working for providers report their Level 1 authorisations to the government's Senior Authorising Officer?
9. What reporting requirements should there be for providers to tell the government's Senior Authorising Officer about their use of restrictive practices?

Qualifications and experience

10. What qualifications and/or experience should be required for Authorised Program Officers working for providers?

11. What qualifications and/or experience should be required for the government's Senior Authorising Officer?

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5.1. Level 1 and 2 restrictive practices

5.1.1. Metro focus group

The Metro Focus Group participants discussed the fact that all restrictive practices are high impact for the person who is subject to them and that categorising practices as Level 1 or 2 without context is fraught with ambiguity and grey areas. Additionally, all restrictive practices should only be a last resort. The group was concerned that the categorisation of levels introduces complexity into the arrangements, stating that, as a worker, one would have *“a hell of a time to figure out what I’m allowed to do.”* A participant summed up their frustration with this element of the design, stating: *“If we are going to do it, at least do it properly ... I think that they are just covering their arse with this.”*

Given the complexity of introducing new levels, participants unanimously agreed that education, training, and awareness across all stakeholder groups would be the key to the effectiveness of the new arrangements. They stated that this would require an investment of resources and effort by the government to facilitate a smooth transition.

Notwithstanding the grey areas, participants agreed that seclusion and environmental restraints – which some participants suggested can come close to having a similar practical effect as seclusion – had a greater impact on a person. A participant described their fear of being trapped and unable to leave a location, describing: *“There’s a situation and I don’t like it, I can’t get away.”* In this scenario, choice and control is removed. The participant stated that there is a lack of appreciation or understanding by workers of why a person might wish to leave a location or the fact that that wish should not require a justification in any case.

Many in the group supported the adherence of the new arrangements with nationally accepted definitions and standards and some suggested that authorising requirements could similarly be developed nationally. A participant stated: *“It doesn’t make sense to me that we wouldn’t have a national system, we should be using a national system”*, while another said: *“I think there should be an overriding national body that everyone’s answerable to.”*

5.1.2. Regional focus group

The regional focus group agreed that the designation of particular restraints as Level 1 or 2 overlooked the important considerations of the individual and the situation, with one participant stating: *"It's so hard without context ... all of them could be Level 2 based on the context."* The group felt there is a lot of ambiguity in creating categories and the process for authorisations will need to be robust to ensure the broader context is fully considered in decision making. The group agreed that judgements about restrictive practices should be individualised and not made on the basis of a *"black and white"* approach. One participant stated, *"People with disabilities are all different,"* while another added, *"You can get two people with the same disability, but they are totally different."* They also repeatedly emphasised the need to view all restrictive practices through the prism of individual rights, with one participant wishing to remind government that they are *"still a human being living a completely different experience."*

Some participants were concerned about the complexity of applying levels given they had not received support or assistance as carers in the past. One stated, *"That sort of stuff, I had to work out for myself"* while another stated that in regional area carers simply *"have to do the best you can with the situation."*

Notwithstanding the concerns about the approach of using levels, a number of participants were concerned about the proposed levels for chemical restraints, particularly those that cause sedation. In provider settings, inadequately trained workers make decisions about when to use medications that are prescribed on an 'as needed' basis and this is high risk, including potential side effects that may be compounded by overly frequent use. One participant expressed the view that chemical restraints should be judged on an individual basis, but most felt that higher level precautions are needed. A participant said, *"Chemical restraint has its place, but you have to have the knowledge [to apply it]."* The group concurred that to apply chemical restraints on an 'as needed' basis, providers should have rigorous procedures and workers need higher levels of training than what is generally offered at the moment.

It was also agreed that seclusion should be Level 2, although concern was raised that both environmental and mechanical could indirectly result in a situation bordering on seclusion.

Most felt that a person's level of vulnerability was highly individualised and could not be categorised appropriately by applying particular rules to priority groups based on characteristics like a person's age. Some participants noted that in regional areas there is often greater availability of supports for children and it can be adults who fall through the cracks, with one stating: *"Once they turn 18, it becomes really difficult."* The regulations should be designed to safeguard the most vulnerable and then everyone is protected.

Additionally, a participant suggested that active steps should be taken to reduce vulnerability through capacity building for people living with disability that includes a focus on knowing their rights. Participants reported that currently many people receiving NDIS services and supports are *"so grateful to have someone with them"* that they would not dare to complain about anything. A support worker described that after a discussion with a client, a guardian had said to the support worker, *"I can't believe he had the confidence to say it to you."*

Recommendation 1

That the South Australian government invest in education and awareness about restrictive practices authorisations prior to implementation, and on an ongoing basis thereafter, to ensure that the new arrangements are well understood by all stakeholders. It should provide clear guidance on the categories of practices that constitute Level 1 and 2 restrictive practices, including practical examples, and this guidance should be tailored and accessible to people living with disability and their families, guardians and carers, as well as the disability sector as a whole.

Recommendation 2

That the South Australian government consider elevating all chemical restraints to Level 2, or, at a minimum, chemical restraints used on an 'as needed' basis should be added as a category of chemical restraints within Level 2.

5.2. Prohibited practices

5.2.1. Metro focus group

Metro focus group participants want South Australia to reduce and eliminate the use of all forms of restrictive practices and emphasised that none of the restraints constitute an ideal response to behaviours of concern. One participant contemplated: *“If you can stop a restrictive practice before it happens, wouldn’t that be ideal?”* For participants, most of the focus is on avoiding the need to use restrictive practices through alternatives rather than prohibition. All participants agreed that a renewed focus on education and training to implement alternative strategies should be a top priority. Many felt that the current training for disability care, particularly the Certificate IV, is inadequate to prepare staff for the breadth of circumstances they will encounter in the sector. One participant stated: *“Everybody who works in disability should be trained to the enth degree.”*

Notwithstanding the consensus to aim to avoid all restraints, some participants considered physical restraints to be even more problematic than others. One participant argued that physical restraints should be prohibited, stating: *“It is the most barbaric one in my mind and it’s the one that, although frowned upon, it is still used a lot.”* Often physical restraints are applied pre-emptively before, or reactively after, a behaviour occurs, and, therefore, not in direct relation to the behaviour itself as it happens. Pre-emptive and reactive uses of restraints are problematic, with pre-emptive use often resulting from being too risk adverse while reactive use is usually punitive.

Participants noted that continuing to allow practices can act as a disincentive for seeking and using alternatives and, therefore, tighter controls on what is allowed may be needed to reach goals for reducing and eliminating the use of restrictive practices. A participant described this problem: *“If you have the right to hold someone down, you will just go to that. ‘Am I able to hold this person down?’, ‘Yes’, so I will”,* before another added, *“If you just said no to physical restraint, then they would have to do something else. If you just took that out, then providers have to learn a different way.”*

The alternative view offered by some participants is that alternatives may not work in all situations or that they may take time to work.

5.2.2. Regional focus group

Like their metro counterparts, regional focus group participants quickly shifted the focus from prohibiting specific restraints to avoiding the need for any restrictive practices to be used. The group saw the biggest impediment to this as a *“poor quality workforce”* that does not really care and reflected on their view that there are *“lots of people out there who shouldn’t be in this job”*. For example, a participant reported a worker not turning up to take a person shopping and not notifying anyone, therefore the person had been *“eating vegemite toast for a week”* without complaining to anyone. Further, another participant indicated that many workers *“just do it because they need a job”* and they see disability work as *“easy money”*, but *“doing the job properly is not easy money.”*

The advent of the NDIS has created a perception among some that there is a lot of money available in the sector. Participants indicated that they thought most problems with restraints are linked to workforce issues, including workers removed from one job for misconduct quickly gaining employment elsewhere due to the shortage of available staff.

Education and training was a common feature of the discussion, with suggestions including annual refresher training on using restrictive practices properly and seeking out alternatives. Some participants want disability workers within the NDIS to be registered and to meet minimum requirements and annual obligations for training and professional development. Likewise, health professionals in fields that already require registration should have disability training included as part of their mandatory professional development. A participant highlighted that the greatest benefit of professional registrations is that they force people to up-skill. However, one participant feared that *“the whole subject is too big, you’re not going to be able to educate everybody.”* Another reflected that currently *“staff are not creative – if that doesn’t work, try a different tact.”*

The size of the pools of staff providing support and the lack of continuity of care was also identified as a trigger for extra restrictive practices. One participant stated that her son had a pool of 25-30 staff and that this *“only adds to his issues.”* Things as simple as familiarity

and rapport between the person and their support worker can go a long way to reducing the need for restraints, yet often the greatest focus is on far more complex regulations rather than getting the basics right. Some support workers worry about taking holidays due to their fear for what may happen to their clients in their absence.

Some participants suggested that rather than banning specific practices, the regulations should focus on restricting how high impact restraints can be used, such as by putting a time limit on how long a specific form of restraint can be applied. Likewise, the repetitive use of what may in a single use instance be regarded as a lower impact restraint, could produce compounding impacts at a much higher level. A participant stated, *“Everything is necessary, if used in the right way.”* Another wanted a greater focus within the regulations on proportionality and the weighing up of risks in the specific context before using restrictive practices. This should not be done by checking off a list, but through a holistic assessment of the person, the behaviour of concern, and the situation: *“Just because it’s your process doesn’t mean it’s the right process for this person.”*

Recommendation 3

That the South Australian government and the NDIS Quality and Safeguarding Commission address the myriad of workforce issues affecting the disability sector that result in an increase in the use of restrictive practices on NDIS participants in South Australia.

5.3. Risk of harm

5.3.1. Metro focus group

Participants in the metro focus group were concerned about how easy it can be to use restrictive practices as a first response rather than a last resort and highlighted that strong protections and clear wording are required in the regulations to prevent overuse and misuse. Participants feared that decisions *“made on the fly”* may lead to inappropriate applications of practices while some providers may have an extreme aversion to risk whereby any perceived danger becomes a justification for restrictive practices and a person’s dignity of risk is cast aside. Similarly, participants underscored that there is a risk

that applying restrictive practices actually escalates behaviours of concern leading to more restrictive practices being used in a cycle that is detrimental to everyone. More attention to the environment and people in the environment as triggers of behaviours of concern could also reduce the need to use restrictive practices. A participant reflected that sharing a space, particularly a home, requires negotiation, while another added *"A little tiny thing can flick you."*

Participants highlighted that there is a potential for harm associated with the use of restrictive practices; not just a 'risk of harm' from behaviours of concern. Participants stated that there is currently overuse and misuse of restrictive practices in the disability sector. Group homes and accommodation arrangements for young people were of particular concern to some participants who perceived there to be a greater likelihood of inappropriate use of restrictive practices, including applying restrictions that may be appropriate for one resident to all others in the same setting. Understaffing or staff convenience were also seen as significant risk factors that may prompt workers to *"go to what's easiest."* A participant stated that in discussing the topic, *"One's mind immediately goes to the worse case scenarios"* of the overuse and misuse of restrictive practices.

To this end, participants believed that the proposed definition of 'risk of harm' in the regulations seems overly broad and open to various interpretations. One participant was concerned that 'risk of harm' may be read as *"could cause a risk of harm"*, while another stated: *"I feel like it's too broad. If you want to, you can invent a risk of harm."* A participant emphasised how words used can influence responses and outcomes, describing language as a *"powerful tool"*. Even when the use of a restrictive practice is part of a behaviour support plan and appropriately authorised, there may still be significant interpretation exercised by providers and staff as to when and how often a practice is used.

Therefore, participants agreed that the words used in the regulations are important and 'risk of harm' should be carefully and precisely defined with a view to setting a clear standard for how it is interpreted.

Additionally, participants raised fears about how the new arrangements for NDIS participants may intersect with other settings, such as aged care, education, child

protection, law enforcement, and correctional services, where requirements and interpretations may differ. They expressed concerns that people living with disability and mental illness are extremely vulnerable in these settings and will not be protected by the new arrangements. They foresaw significant gaps as a result and suggested that there should be a broader review of legislation and approaches across all settings to close any gaps and clarify any grey areas of regulation. Some felt that when police are called into disability settings due to behavioural escalations they tend to use inappropriate or unconstructive levels of power and force, which could be addressed by the South Australian government as part of these new arrangements. One way of doing that would be to apply the restrictive practices arrangements in all setting regardless of the location of the NDIS participant.

5.3.2. Regional focus group

Some regional focus group participants considered 'risk of harm' too open to interpretation, with one stating: *"We know that in the disability care sector there are some carers who don't follow the rules already."* Therefore, the strongest protections need to be created to circumvent interpretations of 'risk of harm' that give too much leeway to providers and workers, particularly an unsupervised support worker who may seek to justify actions outside of accepted practice: *"There are too many instances where one person's opinion might be different to ten other people."* Instead, some participants favoured an approach based on a risk assessment of the restraint and the behaviour of concern where the proportionality of the use of a restraint would need to be justified.

On the other hand, a participant highlighted that the 'risk of harm' can be very real for workers and that they need protections, otherwise retention rates will decline further: *"I don't get paid enough to have that done to me."* Another contemplated, *"You can't really wait for them to do something because if you waited they could have caused too much harm, but by not waiting, they might've done a lot of harm to the person."*

Regional focus group participants also held concerns about what occurs in group homes, the rules that are enforced, and the manner in which residents are treated.

Recommendation 4

That the boundaries of the concept of “risk of harm” be more clearly defined in the regulations to reduce the potential for interpretations to be applied that are too broad or overly risk adverse, to give increased weight to the proportionality of responses, and to ensure that dignity of risk is upheld.

Recommendation 5

That the South Australian government prioritise its review – which the Minister for Human Services has indicated is underway – of restrictive practices across all settings and work to build greater consistency and protections for all South Australians, particularly where disability and mental health intersects with other settings, such as law enforcement and correctional services.

5.4. Notifying person subject to restrictive practices

5.4.1. Metro focus group

Metro focus group participants were united in arguing for the person to be placed at the centre of the regulations. They spoke of people living with disability being ignored and not being listened to, with one participant drawing attention to *“how tiring it is to always explain your situation.”* Often, the underlying causes of a person’s behaviour are not considered. Participants noted that behaviour is a form of communication and that greater effort should be made to understand what is being communicated, with one participant stating that if they were *“not heard or listened to at any time of day, I would want to punch a wall too.”* Another participant stated that too often the disability community is *“infantilised”*, while another wanted an end to others making decisions for them under the familiar theme of, *“It is for your own good,”* particularly given the fact that, *“To make the decision for a person takes away dignity.”*

Participants concurred that the individual should be involved to the greatest extent possible at every stage of the process. Information should be shared with them from *“the very beginning”* in order to facilitate maximum input. However, some suggested that the

frequency of ongoing notifications for the use of restrictive practices should be set according to the wishes of the person or their support person. Likewise, the person should be able to choose who is notified. Nevertheless, participants indicated that notifications are an important protection and essential for progress evaluations and review processes to work well.

Any approach that treats a person's involvement in the development of a behaviour support plan as a substitute for a person's involvement with the authorisation process is impacted by the quality of the planning process and its outcomes. Participants did not believe that plans are currently meeting minimum standards of quality and consultation, or that the necessary staff time allocations for positive behaviour support approaches to be implemented are being made. This is despite participants perceiving that the NDIS has injected a lot of money into providers within the disability sector, with one participant observing that *"as soon as you mention you're NDIS, it goes ka-ching, dollars."* Another added, *"It's all about soaking up their plan."*

In order for the individual to be involved to the greatest extent possible, participants suggested that there should be an option for a person who is subject to restrictive practices to receive support and advocacy assistance from an independent person. A participant stated, *"I stand up for myself, but I'm unusual."*

Participants agreed that a person should be given the opportunity to direct forward planning while their capacity is higher for when plans may need to be implemented, with one participant describing: *"The person can say, 'Well, when things are really bad, this is how I deal with it'."*

5.4.2. Regional focus group

The regional focus group wanted greater recognition of the individual in the new arrangements and more respect for people living with disability in our society. They reiterated that governments should *"look at the person"* and not just apply labels. One participant said of his friends, *"People shouldn't have labels, everyone has different ability ... people think there's something wrong with them, but I don't see them as having anything"*

wrong.” Inclusion was a strong theme, with one participant stating, “The person receiving the care needs to actually be part of it and, if they can’t, their primary carer.”

The group agreed that the regulations need to respond to the prevailing conditions in society where people living with disability and their carers struggle to be heard by including strong requirements for information provision, consultations and notifications to counter this. The regulations need to prevent the culture of *“I don’t have to care about you like anyone else”* from providing the basis for how people are treated. One participant reported, *“I have heard a lot of stories of: ‘This is what we think, so this is what you’re getting’, but they’re not really consulted.”* The regional group concurred with the metro group in urging greater involvement of a person when they are well, with one participant stating: *“Talk to them when they are fine, plan for when they are not.”*

Participants lamented the lack of behavioural specialists in regional areas and laughed ironically at their prospects for them accessing services to develop behaviour support plans within a small regional community, as required by the arrangements. One participant stated that their 22-year-old son had never received any behaviour support. Another said that in *“a town this size, we can’t access speech therapy, occupational therapy...”* before describing regular long car trips to access services that are taken for granted in metropolitan areas. Even when a plan is developed, there is typically no availability for follow up. In both medical and allied health settings there is a lack of continuity of care with people forced to see a different person each time. With limited access to services and supports, there is little capacity building to assist in reducing the need to restrictive practices.

Participants want notifications to be required at the earliest point restrictive practices are considered to facilitate input from all relevant parties. However, a participant suggested that notification requirements for ongoing uses could be more flexible and reflect the form of restraint applied and its broader context, rather than applying a standard rule, stating *“You can’t be writing about it every time you say ‘no sugar’.”* Another stated, *“That is what makes it so tough, with the smaller things that are everyday things.”* Authorisations could indicate the frequency of notifications required, thereby allowing the person subject to a restrictive practice or their support person to request particular arrangements.

Where notifications are required they should be fully transparent and comprehensive, covering what was done, why it was done, what other strategies were tried, and why there were no other options. This will assist in keeping everyone “*on the same page*” as well as ensuring authorisation reviews or appeals can be pursued in a timely manner. A participant also highlighted that not being provided with documentation can cause further problems in the future when records of a person’s life are needed.

Recommendation 6

That the person living with disability be placed at the centre of the regulations with supported decision making approaches made a key feature of the authorisation arrangements. Accordingly, the regulations should require that the person subject to restraint, or when appropriate a support person of their choice, receives timely and fully transparent notifications of both the authorisation process and the use of restrictive practices. For ongoing use, the person subject to restraint or their support person should be able to request how and when they are notified and to have this included as a condition of an authorisation.

5.5. Reporting requirements

5.5.1. Metro focus group

Metro Focus Group participants agreed that timely reporting is essential for any red flags to be raised promptly. Long reporting timeframes could allow problems to be overlooked for an extended period. One participant stated that if a restraint is being used daily then a reporting period longer than each week could have serious consequences. However, another participant suggested that providers are likely to be resistant to weekly reporting and monthly requirements may be a more realistic expectation.

Participants then discussed the opportunities of digital technologies and integrated systems for real time reporting of each session or shift undertaken where information would be immediately available to authorities and viewable by the person subject to a restraint or their support person via an app. The group urged the government to investigate systems used elsewhere and to adopt and adapt a technological approach that would streamline administration and recordkeeping to enable a greater focus on risks and protections.

One participant was concerned about the confidentiality and privacy of the information reported and wanted a requirement included in the regulations for the SAO to only report de-identified data publicly. A question was also raised about provider liability regarding restrictive practices with a participant feeling uneasy with a lack of accountability and responsibility for the potential consequences of restrictive practices in terms of both injury and dignity, stating: *"We are dealing with real people."*

5.5.2. Regional focus group

As indicated in the above section on notifications, the regional focus group tended to favour a flexible approach to the frequency of information sharing regarding the ongoing use of restrictive practices based on the form of restraint, the individual involved, and the broader context. However, most felt that any change in circumstances should be required to be reported promptly to ensure there is appropriate oversight. One participant emphasised that reporting requirements need to be purposeful and not simply paperwork that is filed away.

Recommendation 7

That reporting requirements for each Level 1 authorisation be streamlined through the implementation of a digital portal or online system with integrated functionality between providers and the SAO. This could include a function to automatically lodge an authorisation granted by an APO to the SAO as it is finalised in the provider setting. In the absence of such a system, each authorisation should be reported to the SAO as soon as practicable after being granted by an APO.

Recommendation 8

That providers report their ongoing use of restrictive practices through a streamlined digital portal or online system according to a standard timeframe that should be no longer than one month. When more frequent reporting is warranted in a particular case, the SAO or an APO should have the option to attach a condition to an authorisation to create a non-standard reporting timeframe under that authorisation.

5.6. Qualifications and experience of SAOs and APOs

5.6.1. Metro focus group

Metro focus group participants emphasised that appointing the “*right people*” to the SAO and APO roles would be extremely important for the new arrangements to be effective. They agreed that the qualifications and experiences required for the roles should not be defined too narrowly as people from a range of backgrounds could succeed in the positions.

Participants preferred a greater focus on values and lived experiences than formal qualifications. Views expressed included: “*You can have a qualification and be totally incompetent*”, “*Life experience [matters], not somebody who’s just read it in a book*”, and “*It’s great if a person has qualifications, but a lot of people have experiences [that make them a] better worker, better person.*” The key values identified were courage, honesty, integrity, and compassion, while the ability to be highly observant and “*alert to what is going on around you*” in order to notice “*the person who is in distress*” would be crucial. Additionally, the ability to relate to people and not to present as “*aloof*” is important.

It was recognised that values are much harder to identify and assess in recruitment processes than formal qualifications, but are potentially more consequential. One participant described: “*How do you measure somebody who has the courage to stand up? But, courage is certainly one of the things [needed].*” A carefully considered and designed recruitment process can help overcome this including scenario-based assessments. They agreed that the inclusion of people with lived experiences in the appointment processes would be critical to identifying candidates that are a good fit for the roles, thereby reducing misunderstandings of the needs of people living with disability and building confidence in the office.

To the extent that formal qualifications are to be considered, participants indicated that a background as a psychologist, disability sector manager, social worker, developmental educator, human rights lawyer, or similar ethics-based profession would be appropriate. Participants thought that the role of SAO would include the exercise of both authority and influence to lead, oversee, and educate the sector. This would require a broad knowledge of disability, insights through relevant work experiences, engagement with current practices,

and a thorough understanding of relevant legislation. One participant suggested that knowledge to apply universal design principles to processes and procedures associated with the new arrangements is also important.

Participants were extremely concerned about the conflict of interest inherent in the roles of APOs given that these people would *“serve two masters or two mistresses”* in terms of their employer and the SAO in line with their obligations according to the authorisation arrangements. One participant described this as an *“absolute recipe for people being bullied, controlled ... to be mute if your job hangs in the balance.”* The profit motive of some providers was also viewed as an impediment to an APO meeting their obligations, with one participant fearing they will not *“feel free to tell the truth”*. Where a provider has its head office located in another state, there may be gaps in the supervision or lines of communication for an APO working in South Australia. One participant emphasised that the regulations need to take account of conflict of interests and ensure there are clear protections for APOs.

Given these concerns, participants unanimously agreed that additional education and training for APOs would play a crucial role. APOs were viewed as an *“on the ground”* role that would require strong skills in listening and relating to people, as well as a willingness to learn who a person is and what is appropriate for them: *“not a one-size-fits-all approach.”* The ability to oversee staff and the use of practices in a constructive way is also important. Additionally, one participant highlighted the need for APOs to be realistic and not overly cautious or risk adverse: *“To be able to hold back where needed, not to jump on it straight away.”*

There was broad support within the metro focus group for the introduction of Community Visitors for the disability sector to create an additional line of sight and act as a safeguard.

5.6.2. Regional focus group

The regional focus group's sense of distance and remoteness from the restrictive practices arrangements and associated authorising roles was palpable. A number of participants were sceptical about the role of the SAO due to the distance between the role and the person subject to restrictive practices. One stated, *“The trouble with that is that these people don't*

know the people” while another stated, *“There’s always going to be issues when it becomes really impersonal.”* Another participant reflected that the person authorising a restraint needs to *“know the person really, really well. [Otherwise] someone comes from Adelaide and sees the person once and then says, ‘this, this and this’.”* A number of participants felt disrespected, with one describing, *“Everyone thinks they know more than I do. If you have a child with special needs, you know that child better than anyone.”* Likewise, another participant stated that professionals need to stop using their qualifications to *“stand over us.”*

One participant strongly disagreed with the SAO playing any role in authorisations, arguing the person will be *“too high”* in the hierarchy to be an effective decision maker in the lives of people living with disability: *“A SAO is never going to be personal ... it’s what they think rather than fact ... They shouldn’t have the authority. I don’t think someone that far up the chain can have any relevance to what a person needs.”* Further, the SAO is unlikely to have adequate funding or support staff to do the job well, so *“How do we figure out what we can do with what we have got?”* In response, other participants emphasised that small things could make a big difference: *“Respecting people doesn’t cost money”* and *“Attitude doesn’t cost anything.”*

Some participants wanted the design of the authorisation process to focus on *“How do you keep it personal?”* and ensure there is a strong values base and moral compass applied. Lived experience of disability or as a carer would be looked upon favourably by the group. Trust is also extremely important, with one participant asking the government to reflect on, *“Who does [the client] trust enough to make that decision?”* The SAO needs to welcome the contributions of families and family doctors in the process and *“keep the door open”* as circumstances change. Therefore, strong listening and communication skills are essential, together with the ability to exercise patience and relate to people at all levels. Familiarity with communicating with people using various types of assistive technology would be very beneficial. One participant foresaw that the SAO would also need to draw on skills in mediation and conflict resolution.

Participants considered that practical experience in disability or aged care settings where care plans and restrictive practices are used as well as in roles that involve leadership,

education, and training should be highly regarded. One participant added: *"You don't want someone who is high up in administration because that's just paperwork and ticking boxes."*

A further suggestion was that a group of people bringing a range of attributes to the authorising office may achieve better outcomes than a single person being appointed as SAO then employing staff beneath them.

A regional focus group participant also raised the issue of APOs having a conflict of interest and feared that provider profits or an APOs ongoing employment might interfere with people's rights: *"Clients and families are basically a pay check."*

Recommendation 9

That requirements for the qualifications and experience of the SAO and APOs be broad to ensure a wide pool of potential appointees, however the regulations should indicate a preference for lived experience.

Recommendation 10

That the regulations require that the selection panel and the decision making processes for the appointment of the SAO include at least two people living with disability.

Recommendation 11

That the regulations require that the SAO provides mandatory training to APOs prior to authorising them to authorise Level 1 restrictive practices in a provider setting. This training should include the first-hand lived experiences of people subject to restrictive practices.

Recommendation 12

That the South Australian government make provision for the office of the SAO to have a meaningful presence in rural and regional South Australia to ensure the office provides support and is available to those communities on an equal basis with Adelaide. The SAO should conduct genuine consultations with rural and regional stakeholders on a regular

basis to bridge the current gap between these communities and the governance of disability services and supports.

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6. Conclusion

JFA Purple Orange thanks the Department of Human Services for the opportunity to assist them with their consultation on the proposed *Disability Inclusion (Restrictive Practices—NDIS) Regulations 2021*. We hope that the feedback from the two focus groups will be of assistance as the government works towards the implementation of its new authorisation arrangements.

The process has generated a range of valuable commentary from disability community sectors, reflecting that this was a good decision by DHS to seek those views. The views have given rise to a range of consumer-informed recommendations that can help strengthen the relevance and impact of regulations in relation to restrictive practice, and with the person's rights, voice, humanity and life chances uppermost in mind.