2025

Being
Mental Health Consumers

Consultation Paper

A legislative framework to regulate restrictive practices

Contents

Introduction

In responding to this consultation BEING's primary focus is on the human rights of people with psychosocial disability who also have access to NDIS supports. While we note that the Disability Royal Commission recommended a staged implementation of the senior practitioner role,[i] we believe that it is important to consider the complexities of applying this model in NSW Government mental health settings at the earliest possible time. We have outlined some of the issues and complexities that might be involved in aligning different legislative and policy frameworks in our responses below.

Recommendation 6.35

Recommendation 6.35 of the Disability Royal Commission suggests that all Australian jurisdictions develop legally binding frameworks for the oversight of seclusion and restraint. The recommendation advocates for consistent principles in the application of seclusion and restraint in disability, health, education, and justice settings for all people with disability in any given jurisdiction. Achieving consistency around the decision-making principles for the use of seclusion and restraint in all these settings would provide people with psychosocial disability with greater transparency about how decisions are made even when they transition between different care provision settings.

NSW Government response to recommendation 6.35 [ii]

In their response to recommendation 6.35 the NSW Government committed to reducing and where possible eliminating the use of seclusion and restraint against people with disability. It should also be noted that the NSW Government stated that it was still considering the best way to achieve this from a legislative perspective. The current Department of Communities and Justice (DCJ) process provides an opportunity for these supportive comments to be converted into an active whole of government reform process that includes education, health and the DCJ.

Senior practitioners in each state

Central to recommendation 6.35 is a model in which each jurisdiction has a senior practitioner whose role is oversight of the use of seclusion and restraint of people with disability in that jurisdiction.[iii] We believe that having senior practitioners in each jurisdiction would provide a mechanism to support the transition towards a mental health, and more broadly, disability care system that is more transparent and consistent in the use of seclusion and restraint.

We also believe that oversight of seclusion and restraint can support and help to facilitate the elimination of the use of seclusion and restraint against people who have NDIS funding. We note that this would be in alignment with commitments Australia has

made as a signatory to the *Convention on the Rights of Persons with Disabilities* (CRPD).[iv]

We also support the proposal to establish Authorised Program Officers (APO) and believe that this would be a practical way to ensure that the principles of recommendation 6.35 are implemented across several different legislative and policy settings. However, we also note that the proposal utilises a narrower model of the senior practitioner role that takes recommendation 6.35(b) as core principles without including the more radical reform recommendations included in recommendation 6.35(c). Most important here is the recommendation to progressively eliminate seclusion and restraint.

In line with both the CRPD[v] and recommendation 6.35(c), BEING strongly believes that seclusion and restraint should ultimately be eliminated from all settings and replaced with mechanisms that provide those with psychosocial and other impairments with effective decision-making supports. This component of the Disability Royal Commission's recommendations should be included in the core structure of the senior practitioner role. The elimination of seclusion and restraint will only be achieved if services progressively work towards replacing these practices with other alternatives.

Proposed NSW implementation

In general terms we welcome the DCJ for initiating the process of developing a framework for NSW that aligns with the recommendations of the Disability Royal Commission. It is a productive goal to move towards greater consistency across care and support settings and between states.

BEING's response to specific questions

Question 2 – Which other settings should the legislation cover.

We note that recommendation 6.35(b) called for a staged implementation of the senior practitioner role, however we believe that the oversight role should ultimately have the capacity to review seclusion and restraint in NSW Health settings such as inpatient units and emergency departments. The senior practitioner role would then supplement the regulatory structures that already exist under the *Mental Health Act 2007 No. 8* and the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020 No. 12*.[vi]

These include the Official Visitors Program (OVP)[vii] and the Mental Health Review Tribunal (MHRT).[viii] We note that the suggestion has been made that the NSW Civil and Administrative Tribunal (NCAT) could be an appeals body under the proposed new legislation,[ix] however in the case of mental health inpatient units in NSW, it will be important to ensure that the proposed new roles and powers not be in conflict with the regulatory structures that already exist under the *NSW Mental Health Act 2007, No 8*.

In any case addressing and working through the different legislation and related regulatory bodies must be a component of the process of developing this framework for NDIS recipients. Agreement ought not to be assumed but rather established through consultation of all the relevant stakeholders.

Question 3 – Issues raised by there being different frameworks.

The diversity of criteria for the authorisation of restrictive practices between different services provision settings is confusing for consumers.[x] Consumers should be able to transition between mental health, supported living and other services, without having to navigate confusing changes in the way seclusion and restraint decisions are made. Consumers should also be able to easily access a single complaints process if they wish to complain about the use of seclusion and/or restraint, or to request a review of behaviour support plans and/or a decision made.

We believe the senior practitioner role has the potential to provide a simpler point of contact for initiating complaints processes about the use of seclusion and restraint. We note that the scope of the MHRT is currently more limited and focuses primarily on the review of involuntary treatment in the inpatient system and of community treatment orders.

Consideration should also be given to the Disability Royal Commission recommendations 11.3 and 11.4 when balancing the diverse legislative frameworks involved here. We note that recommendation 11.3 recommends that every jurisdiction establish a one stop shop complaints mechanism, while recommendation 11.4 recommends creating accessible complaint pathways through the establishment of a national 1800 number and website, supporting access to each jurisdiction's complaint mechanisms.

In their response to the Disability Royal Commission, the NSW Government accepted both recommendations 11.3 and 11.4 in principle.[xi] Their response also suggested that the Government already performs some of the requisite functions particularly through the NSW Ageing and Disability Commission.

We urge that the NSW Ageing and Disability Commission be consulted, if they have not already been already. We also note that the NSW Ageing and Disability Commission is already underfunded and under resourced for its current functions, especially its role in administering the Official Community Visitors Scheme.

Therefore, regardless of who the complaints body is, the body must have sufficient resources and funding to discharge its functions effectively and proactively.

Question 4 – Should the principles at 6.35 (b) be the core principles.

We support the Disability Royal Commission recommendation 6.35(b).[xii] The key principle of ensuring that treatment is always the least restrictive possible treatment

aligns with the core principles of the NSW *Mental Health Act 2007 No. 8* and the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020 No. 12* which already tests decisions relating to involuntary treatment against the principle of least restrictive treatment .[xiii] This is a strength insofar the proposed oversight mechanism will be able to align with the *Mental Health Act 2007 No. 8* and the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020 No. 12* without requiring extensive legislative reform.[xiv]

Question 5 – Should any other principles be considered?

We believe that the core principles of the jurisdictional senior practitioner roles should also include promoting the reduction and elimination of the use of restrictive practices as per recommendation 6.35(c).[xv] Australia has committed to eliminating seclusion and restraint as a signatory to the CRPD[xvi] and the Disability Royal Commission has reflected this in its recommendations. NSW and other Australian jurisdictions ought to do more to include this commitment in any new legislation that applies to people with disability.

In the interim it would also be appropriate for staff to be employed solely to support people with a disability to engage in decision-making about the limits of seclusion or restraint for that person. Supported decision-making requires staff who can provide neutral support to people with disability during decision-making, which involves both carers and services, neither of whom have a neutral position in relation to the consumer when it comes to seclusion and restraint decisions.

Finally, it is also vital that accountability and transparency are core principles attached to the senior practitioner role. The results of review processes should be de-identified and made available to the public, to provide a body of precedents that will allow future review processes to be carried out with consistency, while ensuring that the logic behind decision-making processes is clear to consumers.

Question 6 – Should any practices be prohibited?

In the first instance, it is vital that recommendation 6.36[xvii] of the final report of the Disability Royal Commission be integrated into the proposed legislative framework. Recommendation 6.36 explicitly identifies practices that should be prohibited in health and mental health settings and in education settings, so these practices must be prohibited.

NSW Health also provides a list of practices that should be prohibited because of the risk of injury to the person being restrained. Included in this list are prone restraint, supine restraint and pin downs amongst others.[xviii] At a minimum, practices that pose medically specified injury risks should be excluded. We note also that misadventure during seclusion can also put consumers at risk. [xix]

While it is vital to consider physical risks, the psychological risks should also not be forgotten. Being subject to seclusion or restraint can also be psychologically harmful. Those subject to seclusion and restraint are at risk of trauma as a result and particularly so if they are subject to repeated episodes.[xx]

Question 7 – NDIS definitions of restrictive practices

BEING believes that the definition of seclusion and restraint should be aligned with the definition developed in carrying out the background research that supported the disability royal commission. We will quote it in full here:

> *"Restrictive practices are legally authorised and/or socially and professionally sanctioned violence that targets people with disability on a discriminatory basis and are at odds with the human rights of people with disability. Restrictive practices include, but are not limited to, chemical, mechanical, physical and environmental restraint and seclusion, guardianship, forced sterilisation, menstrual suppression and anti-libidinal medication, financial management, involuntary mental health treatment, and other non-consensual or coercive interventions said to be undertaken for protective, behavioural or medical reasons".* [xxi]

We note that this definition was developed in response to the complex range of different environments within which seclusion and restraint may be used and noting specific cases which are particularly problematic.

In relation to the issue of definition, we reiterate the relevance of recommendation 11.1 of the Disability Royal Commission, which recommends the development of a nationally consistent safeguarding framework that includes nationally consistent definitions of key terms.

A legislated nationally binding definition of seclusion and restraint would contribute to ensuring consistency of standards across states and agencies when it comes to seclusion and restraint, and improve the evidence base for future policy and program decisions in NSW and across Australia.

Within NSW it should also be noted that the NSW Mental Health Commission is currently in the process of developing a position paper related to restrictive and coercive practices, which would include the use of seclusion and restraint in the NSW metal health system. It would be appropriate for DCJ to consult with the NSW Mental Health Commission around questions raised by the development of the proposed NDIS seclusion and restraint framework.

Question 12 – Who should APOs be employed by

In the mental health context, it seems reasonable that Authorised Program Officers (APO) would be employed by NSW Health. This would be appropriate given that the

senior practitioner role will need to navigate and regulate several different inflections of the core principles depending on the organisational context. This will be easier if APOs are inside the affected organisations.

Further, if APOs are to be employed outside of NSW Health, we would support not-for-profit providers employing them. However, this decision would need to be subject to further consultation before implementation.

Question 13 – Duration of authorisation

Proposal 6[xxii] suggests that the senior practitioner should have discretion to determine an authorisation for up to 12 months. We do not have any specific objections to this timeframe; however, we strongly believe that ensuring the least possible restrictive support options should be a core normative principle when making decisions about timeframes over which a behaviour support plan will apply. In other words, the length of time an authorisation applies for should reflect careful consideration of the least restrictive timeframe. The shorter the period of authorisation the better.

With that said, we also believe that further and targeted consultation with consumers, with civil society and with the relevant government agencies is urgently needed. This is especially important given the complex range of legislation the proposed framework will cover. From the perspective of mental health, involuntary treatment (a form of seclusion) is a core feature of the *NSW Mental Health Act 2007 No. 8* and for this overarching framework to be meaningful and actionable it is important that the development of the framework addresses the full complexity of what it is trying to achieve.

Question 16 – Rights to seek review.

BEING agrees that individuals affected by the authorisation to use restrictive practices should have a right to appeal authorisation decisions. Protecting and supporting the autonomy of individuals being subjected to seclusion or restraint should be the most fundamental consideration.[xxiii] Therefore, this must be central to decision-making processes, while carefully balancing the safety and security of service providers as well as the concerns of other third parties.

While we recognise that NCAT is an established dispute resolution service within the NSW Government, we hold concerns about the lack of disability expertise and limited disability awareness at the Tribunal. In the NSW mental health setting, the Mental Health Review Tribunal may be a good example of how to structure regulatory bodies appropriately in the disability space.

Question 18 – Complaints handling and investigation functions.

The senior practitioner should have complaints handling powers, both on receipt of a complaint and by the senior practitioner's own initiative. BEING also believes that it

would be a progressive move to provide the senior practitioner with the power to respond to systemic issues, including the power to initiate reform processes arising from individual complaints. Having bird's eye oversight will allow senior practitioners to be key agents for legislative reform, and we view this power as crucial to supporting the NSW Government's commitment to reducing and ultimately elimination of seclusion and restraint and other forms of restrictive practices, in line with Disability Royal Commission recommendations 6.35 and 6.36.

Noting that people with disability can over time move through different services,[xxiv] one of the strengths of the proposal to implement a senior practitioner role is to allow for a single complaints body, for different agencies and for state and federally funded agencies. These could include supported living facilities, Housing and Accommodation Support Initiatives (HASI),[xxv] NSW Health emergency departments and NSW Health inpatient mental health units.

The senior practitioner should be provided with sufficient bureaucratic support in each jurisdiction and have appropriate levels of resources and funding to allow for the full discharge of their duties, including the regular review of the use of seclusion and restraint in each jurisdiction, with the ultimate goal of eliminating the use of seclusion and restraint in all disability support settings.

Question 19 – Powers to respond to the misuse of seclusion and restraint

We note that the powers of the current ACT senior practitioner,[xxvi] which has been suggested as a model for the new senior practitioner roles, focus primarily on individual complaints. We believe that as well as investigating individual complaints, senior practitioners should also have a role in overseeing and encouraging the progress made in reducing and eliminating seclusion and restraint.

Senior practitioners need to be both protectors of individual rights and advocates for systemic change. Consideration could also be given to tasking senior practitioners with powers to streamline the integration of supported decision-making processes into NDIS service delivery.

Question 21 – Information sharing

BEING does not believe that senior practitioners should have the right to share any identified information [xxvii] without consent from the individuals concerned unless there is evidence of unjustified use of seclusion and restraint. However, sharing of de-identified data that helps to reduce the use of seclusion and restraint across Australian NDIS services would be a positive way to further implement our human rights commitments to people with disability.

Question 22 – Is the reporting framework adequate.

It would be helpful to have data that is as granular as possible. The new senior practitioners should not view data collection as simply a reporting function, [xxviii] but rather as a key means to achieving the goal of eliminating the use of seclusion and restraint. Data should be used to identify which issues and agencies require improved education and support and in which areas.

Given that ultimately this system of oversight and regulation could have eyes on several different settings including education, health and communities and justice, the potential for senior practitioners to facilitate the exchange of information, skills and programs between agencies should also be explored.

Question 23 – Education and guidance functions

As already stated, BEING believes that senior practitioners should have an educational role. If internal reporting includes a regular sharing of information about internal programs and projects relating to the use and reduction of seclusion and restraint, the senior practitioner could also function as a clearing house. The senior practitioner could also host interdepartmental meetings to achieve similar goals.

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[i] Pg 512 - https://disability.royalcommission.gov.au/system/files/2023-09/Final%20Report%20-%20Volume%206%2C%20Enabling%20autonomy%20and%20access.pdf
[ii] https://dcj.nsw.gov.au/documents/community-inclusion/disability-inclusion/royal-commission-into-violence-abuse-neglect-and-exploitation-of-people-with-disability/nsw-government-response-to-the-disability-royal-commission-recommendations-appendix-a.pdf
[iii] Final report vol 6 pg. 511 – 512, https://disability.royalcommission.gov.au/system/files/2023-09/Final%20Report%20-%20Volume%206%2C%20Enabling%20autonomy%20and%20access.pdf .
[iv] https://social.desa.un.org/issues/disability/crpd/convention-on-the-rights-of-persons-with-disabilities-crpd and https://www.ohchr.org/en/instruments-mechanisms/instruments/optional-protocol-convention-rights-persons-disabilities
[v] CRPD – Article 15 - Freedom from torture or cruel, inhuman or degrading treatment or punishment (https://social.desa.un.org/issues/disability/crpd/article-15-freedom-from-torture-or-cruel-inhuman-or-degrading-treatment-or).
[vi] https://legislation.nsw.gov.au/view/html/inforce/current/act-2007-008 and https://legislation.nsw.gov.au/view/html/inforce/current/act-2020-012
[vii] NSW Official Visitors Program - https://officialvisitorsmh.nsw.gov.au/Pages/OVP.aspx -
[viii] The Mental Health Review Tribunal - https://mhrt.nsw.gov.au/the-tribunal/

[x] We will expand on this in our response to question 7.
[xi] Pg 144, https://dcj.nsw.gov.au/documents/community-inclusion/disability-inclusion/royal-commission-into-violence-abuse-neglect-and-exploitation-of-people-with-disability/nsw-government-response-to-the-disability-royal-commission-recommendations-appendix-a.pdf
[xii] Note that 6.35 b recommends that restrictive practices should only be used as a last resort, as the least restrictive response possible, to the extent necessary to reduce the risk of harm and for the shortest time possible.
[xiii] Subsection 12, General restrictions on detention of persons (https://legislation.nsw.gov.au/view/html/inforce/current/act-2007-008#ch.3)
[xiv] Note the CRPD section and maybe discuss the

[xv] 6.35 c recommends that amongst the roles of the senior practitioner should be promoting the reduction and elimination of seclusion and restraint.
[xvi] CRPD Article 12. While we understand that as a
[xvii] Pg. 516, https://disability.royalcommission.gov.au/system/files/2023-09/Final%20Report%20-%20Volume%206%2C%20Enabling%20autonomy%20and%20access.pdf
[xviii] https://dcj.nsw.gov.au/service-providers/deliver-disability-services/restrictive-practices-authorisation-portal/resources/restrictive-practices-guidance-physical-restraint.html#:~:text=These%20forms%20of%20physical%20restraint,their%20arms%20or%20legs)%3B
[xix] Note that The most recent NSW Health inquiry into the use of seclusion and restraint in NSW Health in patient units (https://www.health.nsw.gov.au/mentalhealth/reviews/seclusionprevention/Pages/about.aspx), was initiated after the death by misadventure of a secluded mental health consumer.
[xx] See key messages at https://www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/minimising-the-use-of-seclusion-and-restraint
[xxi] Pg. 1, https://disability.royalcommission.gov.au/system/files/2023-07/Research%20Report%20-%20Restrictive%20practices%20-%20A%20pathway%20to%20elimination.pdf
[xxii] Pg 33 consultation paper, https://hdp-au-prod-app-nsw-haveyoursay-files.s3.ap-southeast-2.amazonaws.com/3117/3344/0342/Consultation_Paper.pdf
[xxiii] https://www.un.org/development/desa/disabilities/resources/handbook-for-parliamentarians-on-the-convention-on-the-rights-of-persons-with-disabilities/chapter-six-from-provisions-to-practice-implementing-the-convention-5.html
[xxiv] What are some examples for adults with psychosocial disabilities this could include, for example, inpatient units, community mental health, supported living and social housing amongst others.
[xxv] https://www.health.nsw.gov.au/mentalhealth/services/adults/Pages/hasi.aspx
[xxvi] Pg 35 consultation paper, https://hdp-au-prod-app-nsw-haveyoursay-files.s3.ap-southeast-2.amazonaws.com/3117/3344/0342/Consultation_Paper.pdf
[xxvii] Consultation paper Pg 35, https://hdp-au-prod-app-nsw-haveyoursay-files.s3.ap-southeast-2.amazonaws.com/3117/3344/0342/Consultation_Paper.pdf
[xxviii] Pg 36 Consultation paper, https://hdp-au-prod-app-nsw-haveyoursay-files.s3.ap-southeast-2.amazonaws.com/3117/3344/0342/Consultation_Paper.pdf

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