RESPONSE TO CONSULTATION PAPER- A LEGISLATIVE FRAMEWORK TO REGULATE RESTRICTIVE PRACTICES

Contact

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Who we are

Council for Intellectual Disability (CID) is a disability rights organisation led by people with intellectual disability. Since 1956, we have been working to ensure a community where all people with intellectual disability are valued.

We speak up on the big issues, we provide information and learning opportunities, we empower individuals and communities.

Down Syndrome NSW was established in 1980 by parents of young people with Down syndrome. We support all people with Down syndrome to achieve their full potential in life and take their rightful place in the community.

We now provide information and support, advocacy, capacity building workshops, training in schools, community participation programs, pre-natal expert advice, new parent resources and support and specialist employment preparation and connection.

Action for People with Disability is an individual advocacy organisation in northern Sydney.

Since 1978, we have been promoting, protecting, and upholding the rights of people with disability.

The consultation paper is too narrow and prescriptive in scope

We shall below respond to some specific proposals and questions in the consultation paper. However, we shall first set out our fundamental position. We do this because we see the consultation paper as very inadequate in spelling out the relevant issues that should be taken into account in determining an appropriate legislative framework and therefore in asking all the right questions.

The current system of authorisation and consent needs scrutiny and reform. However, the system proposed in the consultation paper has fundamental weaknesses and would represent a fundamental backward step in safeguarding the rights of people with disability.

There is a wide range of issues that needs consideration in deciding on an optimal and practical system for decision making about the use of restrictive practices.

Our fundamental recommendation is for the government to bring together a working group with representatives from the advocacy, positive behaviour support and disability mental health sectors to consider the results of the current consultation and provide advice on the best legislative model for decision making about restrictive practices.

This is the approach recently and successfully taken by the Attorney General in relation to guardianship reform.

Fundamental human rights are involved

Any restrictive practice is inherently a breach of human rights.

Some kinds of restrictive practices fundamentally infringe on the liberty of people with disability including seclusion, mechanical and physical restraint. Some people are effectively imprisoned in their own homes. These restrictive practices are unlawful assaults and false imprisonments under tort and criminal law unless a defence recognised by law is made out.

Any form of authorisation of breaches of human rights needs to be carefully designed and needs to be particularly strong in relation to more major infringements on liberty.

Whilst restrictive practices are sometimes justified in the short term, the clear and strong goal must be to reduce and ultimately eliminate the need for them both in relation to individuals and across the board.

Suggested features of an optimal decision making system

- Person centred, not system centred
- Promoting autonomy with maximum focus on supported decision making
- Consistent with the principles of positive behaviour support
- Safeguards proportional to the nature of the restrictive practice

- Expertise in relation to the person
- Expertise in relation to behaviour support
- A clear sense of where the buck stops, that is who is ultimately responsible for ensuring a restrictive practice is needed and only used in conjunction with robust positive behaviour support.
- However, also based on the range of relevant players having input and taking a shared risk approach. This avoids a risk averse approach .
- Including a point at which there is a focused discussion between all relevant parties including the person, family, behaviour support practitioner, service manager and, where relevant, psychiatrist. (Well run authorisation panels currently perform this role.)
- Complemented by strong systems for standard setting, promotion of good practice, monitoring and data collection and analysis
- Adequately resourced
- Strongly interlinked with NDIS safeguards requirements including compulsory reporting of restrictive practices to the NDIS commission, lodgement of a positive behaviour support plan, and the Commission's capacity to set standards, approve behaviour support practitioners and monitor and investigate the use of restrictive practices.

The consultation paper does not address a key option

Since about 1990, consent and guardianship have been important safeguards on the use of restrictive practices in NSW disability services. In 2021, the Department of Communities and Justice (DCJ) consulted on a proposal to revamp this system within a consent framework. That proposal had many flaws and ultimately did not proceed. However, the flaws in that proposal do not mean that a consent/guardianship approach should be discarded.

There are strengths and weaknesses in revamping a consent/guardianship based approach as opposed to moving to a senior practitioner authorisation approach. The current consultation should have been framed as an options paper considering the two models.

While the existing consent/guardianship system needs reform, it has a clear rationale in being based on consent by the person with disability or consent by an appointed guardian. The guardian is independent of service systems and disability bureaucracies and bound to listen to and act in the interests of the person with disability.

A fundamental weakness of the proposed system of authorisation by a government official (the Senior Practitioner) is that it takes decision making power from the person with disability or their representative.

This sits very oddly with the ongoing national and NSW policy emphasis on enhancement of supported decision making so that people with disability have maximum control over their own lives.

A senior practitioner model may bring professional expertise. It also would bring the potential weaknesses of any bureaucratically based system including remoteness from the person and stretched caseloads.

Family members who conscientiously exercise their roles as guardians in relation to restrictive practices are likely to be very alarmed at the prospect of being disempowered in their advocacy.

A further fundamental weakness in the consultation paper is that it is not based on the wide ranging expertise that comes to bear when government works with the disability community, as has occurred in the current consideration of reform of the Guardianship Act.

We appreciate that the consultation paper is related to the recommendations of the Disability Royal Commission. However, unlike other states and territories, NSW has had a consent/guardianship model for over 30 years and therefore that model should not be discarded lightly.

A senior practitioner authorisation model would be more likely to be consistent with regimes for disability services in other states. However, discarding a consent/guardianship model would equally lead to inconsistency with the regime required for restrictive practices in aged care by the Commonwealth Aged Care Act 2024.

Weaknesses and tensions in the current guardianship system

A disproportionate approach to when a guardian is needed

From 1990 to 2019, NCAT generally took a proportionate approach in deciding whether to appoint a guardian for restrictive practices. The Tribunal generally focused guardianship on the most intrusive restrictive practices like seclusion and mechanical and physical restraint.

The tribunal changed course in the landmark HZC case. (HZC [2019] NSWCATGD 8)

Now, the tribunal sees a guardian as needed for any restrictive practice right through to practices like restricted access to household chemicals or sharp knives to prevent unintended self harm. We see this as a disproportionate approach to when there is a need for the succession of processes that guardianship involves – application to the tribunal, a hearing, appointment of a guardian, the guardian being informed of the situation and the guardian then deciding whether or not to consent to the practice.

Applying this process to all restrictive practices creates a danger of decisions about restrictive practices becoming a matter of process and an illusory safeguard.

Where does the buck stop?

The overlapping roles of the NDIS Commission, Authorisation Panel, NCAT and a guardian leaving no clear sense that “the buck stops here” in relation to ensuring a restrictive practice is needed. This problem is exacerbated by very stretched resources in these institutions.

Who should be the guardian?

NCAT is only allowed to appoint a family member as guardian if they are “able” to perform that role. In some cases, the tribunal may face a dilemma as to whether to appoint a devoted but disempowered family member or to appoint the Public Guardian who is more distant from the person, has very heavy caseloads and may therefore not be able to apply due scrutiny to the situation. The tribunal may safeguard these situations by making short term orders to keep the matter under scrutiny.

What if a restriction is used to protect other people?

Guardianship is focused on the paramount interests of the particular individual whereas some restrictive practices are at least partly focused on safeguarding other people. This concern can be met by demanding to see an overall benefit to the person from the package of restriction and positive behaviour support.

How the current guardianship system could be reformed

The consent/guardianship system could be reformed by including a Restrictive Practices Part in a reformed Guardianship Act with some similarities to the existing Part 5 of the Act which covers consent to medical treatment. Where a person could not be supported to make their own decision about a restrictive practice, there could be categories of Minor, Major and Special Restrictive Practices with similar substitute consent requirements as for medical treatments including the consent of a “person responsible” (usually a close family member) being required for minor or major practices and the consent of NCAT being required for Special Restrictive Practices such as seclusion and physical and chemical restraint.

This approach would facilitate the resources of NCAT and the Public Guardian being much more targeted to cases that needed intensive scrutiny as compared with the current situation where all practices require an application to the tribunal and the resources of the tribunal and Public Guardian are spread thin.

In accordance with current NCAT practice, panels dealing with restrictive practices would be required to include a member with appropriate expertise.

This approach would be complemented by an enhanced systems monitoring and improvement role for the Ageing and Disability Commission in relation to restrictive practices. A Senior Practitioner role at the Commission could be created for this purpose.

Our thinking about reform of the role of guardianship in relation to restrictive practices could be incorporated into a more broadly updated guardianship act or, if necessary in the first instance, into the existing Guardianship Act.

Safeguards needed if a Senior Practitioner authorisation system is pursued

We are inclined to prefer reforming the consent/guardianship approach rather than replacing it with an authorisation system. However, if the Government and Parliament pursue the latter approach, we see the following as key ingredients of it:

- Independence from government - The Senior Practitioner MUST have clear statutory independence and be attached to the Ageing and Disability Commission. The Disability Royal Commission was clear that the Senior Practitioner should be "an independent statutory authority" (Final Report, Volume 6, page 512)
- While the Senior Practitioner might authorise less intrusive restrictive practices, the most intrusive practices should require approval by a three member panel of NCAT. (This panel could be drawn from existing NCAT members who have behavior support expertise.)
- We have grave reservations about service provider Approved Program Officers being given authority to authorise less intrusive restrictive practices. They have clear conflicts of interest. An alternative would be for authorisation to instead be required from the person with disability if they can be supported to make the decision, or, failing that, from a "person responsible" as defined in the Guardianship Act or its successor legislation.
- Maximum input and consultation obligations with the person with disability and their families. Often such requirements are at best lip service in practice. We in fact say consent by or on behalf of the person should be a requirement of any system which could only be overridden in very tightly defined circumstances.

We note the emphasis in the consultation paper on rights to seek reviews by and make complaints to an independent body if a person or their family is dissatisfied with restrictive practices. We see these as very limited safeguards in view of the common isolation and disempowerment experienced by people with disability and their families.

Some restrictive practices should require tribunal approval

Whether the current consent/guardianship system is reformed or a senior practitioner authorisation model is adopted, some restrictive practices involve such grave infringements on human rights that they should require the approval of a three member panel of NCAT. These practices include:

- A practice to which the person objects (including by showing physical resistance)

- Seclusion or environmental restraint that involves confinement of a person to premises or part of premises for any reason other than the person's physical safety.
- Physical and mechanical restraint
- Any further practice as specified by the Ageing and Disability Commissioner. This might include some classes of chemical restraint.

The complexity of chemical restraint

Both the current NDIS safeguards system and, in recent years, the standard practice of NCAT distinguish between chemical restraint and the use of psychotropic medication for treatment of mental health conditions

We see this distinction as very problematic in practice. The distinction is often unclear or in the eye of the beholder or as the prescriber would prefer to perceive it.

We would much prefer to see all psychotropic medications used with people with disability strongly safeguarded rather than having two different systems basically related to the purpose for which the prescriber chooses to characterise the medication.

For example, as well as the need for consent or authorisation, a peer review panel may have a valuable role in promoting best practice and clarity in the rationale for medications.

Decision making systems must be complemented by measures to monitor and promote good practice

We emphasise the following fundamental and chronic deficits in the disability service system:

- Lack of skills in supported decision making and positive behaviour support.
- Inadequate supply of skilled behaviour support practitioners and psychiatrists with expertise in disability mental health.

Whatever decision making system is landed on, it needs to be very strongly complemented by the strongest standards, data collection and education and training in positive behaviour support including the use of supported decision making in devising behaviour support plants. People with disability and their families need ready access to independent information, education and advice about positive behaviour support, restrictive practice and supported decision making.

These roles should be given to a Senior Practitioner located in the Ageing and Disability Commission.

There needs to be a strong dovetailing of roles between the NSW consent or authorisation system and the role of the NDIS Commission including definition of who is responsible for what.

The NSW and Commonwealth Governments also needs to implement strong actions to increase the supply of skilled behaviour support practitioners.

Safeguards in other service systems

We welcome the acceptance that any new legislation should seek to minimise the use of restrictive practices in the range of services systems, not just NDIS services. Preferably, the same consent or authorisation system should apply across the board.

In any case, the Ageing and Disability Commission should have cross sectoral roles in monitoring and promoting good practice in behaviour support and use of restrictive practices.

KEY RECOMMENDATIONS

1. Establish a government/ community working party to consider the results of the current consultation and advise government:
    a. Whether a reformed consent/guardianship approach should be pursued instead of a Senior Practitioner authorisation approach.
    b. Whether a hybrid model should be pursued incorporating elements of a consent/guardianship model and a Senior Practitioner model
    c. The detailed form of the best model.
    d. How best to address the murky distinction between chemical restraint and mental health treatment.

2. As well as representatives from disability advocacy groups, the working party should include independent experts in positive behaviour support and intellectual disability mental health.

3. The working party should be informed by consultations with people who have intellectual disability.

Responses to questions and proposals

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

Yes

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

It should preferably cover all NSW settings in which people with disability are subject to restrictive practices.

Question 3: What issues and challenges are raised by there being different frameworks for the authorisation of restrictive practices in the disability service provision setting and the aged care setting?

Confusion, uncertainty and duplication, especially for people with disability who receive NDIS services and live in aged care, and for providers who operate in both sectors.

Proposal 1: Legislation should provide that the use of restrictive practices on NDIS participants in the disability service provision, health, education and justice settings should be governed by the principles recommended by DRC Recommendation 6.35(b).

Agreed though additional principles should also be considered.

Proposal 2: The legislation should require government agencies in the health, education and justice settings to provide an annual report to the Senior Practitioner on their, and their contractors', compliance with the principles.

Agreed.

Question 4: Do you support legislation requiring that restrictive practices on NDIS participants in the disability service provision, health, education and justice settings should be governed by the principles recommended by DRC Recommendation 6.35(b)?

Yes though additional principles should also be considered.

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

Our proposed working party should consider this.

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

Yes, at least those outlined by the DRC.

Proposal 3: The NDIS definitions of restrictive practices should be adopted for the NSW legislative framework for restrictive practices.

Agreed

Proposal 4: The Senior Practitioner should have the power to issue guidelines that clarify how the definitions apply in different situations.

Agreed

Question 7: Do you agree that:

- the framework should use the NDIS definitions of restrictive practices?
- the Senior Practitioner should have the power to issue guidelines that clarify how the definitions apply in different situations?

Yes

Question 8: What role should the Senior Practitioner play in regulating behaviour support plans? For example:

• Should the Senior Practitioner have the power to prescribe additional and/or more detailed information for inclusion in the BSP? If so, what information?

• Should the Senior Practitioner have the power to require a behaviour support practitioner have certain qualifications and the Senior Practitioner's approval before they can prepare a BSP which will be used to authorise the use of a restrictive practice? If so, what should the additional qualifications and criteria for approval be?

• Should there be any specific provisions relating to consultation in the development of a BSP, in addition to the requirements in the NDIS Rules?

These matters should be considered by the working party that we propose.

Question 9: Is there anything else the proposed framework should do to improve the quality of BSPs?

These matters should be considered by the working party that we propose.

Proposal 5: A Senior Practitioner model should be structured to use APOs as part of the authorisation process. An APO should:

• have operational knowledge of how the BSP and proposed restrictive practice would be implemented,

• be required to meet prescribed professional standards set by the Senior Practitioner, and,

• be approved by the Senior Practitioner.

These matters should be considered by the working party that we propose.

Question 10: Should APOs be empowered to either:

• authorise particular categories of restrictive practices without separate Senior Practitioner authorisation (a partially delegated model). If so, what categories of

restrictive practices should be able to be authorised by APOs? Should these be prescribed by legislation, or through class or kind orders?

• provide preliminary approval of restrictive practices, with final authorisation provided in all cases by the Senior Practitioner (a two step model)? What would be the benefits and risks of the above models?

NO. As officers in service providers, APOs would face unmanageable conflicts of interest.

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

The working party we propose should consider this issue including a consent/guardianship model.

Question 12: Should APOs be required to be employed by a single provider? Or should APOs be permitted to be consultants to a number of providers? If so, what safeguards should there be in relation to this?

As officers in or contractors to providers, APOs would have unmanageable conflicts of interest.

Proposal 6: The Senior Practitioner and APO should have a discretion to determine the duration of an authorisation, up to 12 months.

These matters should be considered by the working party that we propose.

Proposal 7: There should be an emergency use process for restrictive practices before a BSP has been prepared and authorisation given, which should replace the interim authorisation process.

These matters should be considered by the working party that we propose.

Proposal 8: The Senior Practitioner should have the power to cancel an authorisation of restrictive practices where:

- the Senior Practitioner has determined there is no longer a need for the restrictive practice,
- the Senior Practitioner requests evidence to demonstrate the restrictive practice is still needed and the provider fails to provide sufficient evidence,
- the authorisation was obtained by materially incorrect or misleading information or by mistake,
- the relevant provider has contravened a condition of the authorisation, or
- the relevant service provider has contravened a provision of the legislation

Agreed (at least if a senior practitioner authorisation model is adopted)

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

These matters should be considered by the working party that we propose.

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

These matters should be considered by the working party that we propose.

An additional key issue is the wishes of the person with disability.

Proposal 9: An affected person, the NDIS provider and any other person who has a genuine concern for the welfare of the person may seek review of an authorisation decision. The review rights would be:

- first to the Senior Practitioner for internal review,
- then to the NSW Civil and Administrative Tribunal

These matters should be considered by the working party that we propose.

Question 15: Should authorisation decisions:

• be open to internal review?

• be reviewable at NCAT?

These matters should be considered by the working party that we propose.

Question 16: Should rights to seek review be limited to the person or a person concerned for their welfare? Should the service provider have a right to seek review of a decision not to authorise a restrictive practice?

These matters should be considered by the working party that we propose.

Question 17: Should a person have a right to request the service provider review the BSP at any time?

These matters should be considered by the working party that we propose.

Proposal 10: The Senior Practitioner should have powers to investigate the misuse of restrictive practices, on receipt of a complaint and on its own motion.

Agreed

Proposal 11: The Senior Practitioner should have the following powers to respond to the misuse of a restrictive practice:

• direct the provider to do / cease doing something in relation to behaviour support or the use of the restrictive practice,

• cancel an authorisation,

• refer the matter to the NDIS Commission, police or another relevant entity.

Agreed

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

Both

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

Yes

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

These matters should be considered by the working party that we propose.

Question 21: To which bodies should the Senior Practitioner have the power to share information and in what circumstances should the Senior Practitioner be permitted to share information?

These matters should be considered by the working party that we propose.

Question 22: Are the means by which the Senior Practitioner would have visibility of the use of restrictive practices by NDIS providers proposed in this Paper sufficient? If not, what additional information should providers be required to report to the Senior Practitioner? How can reporting burden to the Senior Practitioner and the NDIS Commission be minimised?

These matters should be considered by the working party that we propose.

Proposal 12: The Senior Practitioner should have the following functions:

- developing and providing information, education and advice on restrictive practices to people with disability, their families and supporters, and the broader community,
- developing guidelines and standards, and providing expert advice, on restrictive practices and behaviour support planning.

Agreed

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

Yes

Question 24: Should the Senior Practitioner have the power to impose sanctions for the misuse of restrictive practices, or are existing sanctions for misuse of restrictive practices sufficient? How should the interaction between sanctions provided for under NDIS legislation and the proposed framework be managed?

These matters should be considered by the working party that we propose.

Question 25: Should the proposed framework provide for a legislated immunity from liability from the use of restrictive practices where the use was in accordance with an authorisation and done in good faith?

These matters should be considered by the working party that we propose.

Question 26: Are there any other functions which the Senior Practitioner should have? Should providers in the disability service provision setting be subject to any other requirements?

The Senior Practitioner should have functions of providing information and support to people with disability and their families to enable them to make empowered decisions about behaviour support including decisions about the use of restrictive practices.