A Legislative Framework to Regulate Restrictive Practices

Response to the Consultation Paper on the Legislative Framework

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Mental Health Carers NSW

Introduction

About Mental Health Carers NSW

As the peak body for mental health carers in NSW, Mental Health Carers NSW (MHCN) represents the interests of mental health carers to the NSW Ministry of Health, and provides information, capacity development and systemic advocacy on behalf of mental health carers. It regularly consults with carers across NSW to gain information on their opinions and experiences with the mental health system. MHCN uses the information gained in these consultations to provide feedback on policies and services on behalf of carers to NSW Health and to other health services and policy makers. With its core functions funded by the Mental Health Branch of NSW Health, MHCN developed the Mental Health Carer Advocacy Network (MHCAN) to broaden its engagement with mental health carers in its advocacy and to assist roll out of the NSW Lived Experience Framework.

By influencing changes in policy, legislation, and service provision, MHCN aims to make a positive difference to the mental health system for carers and through the MHCAN to empower carers to become champions for change, sharing their lived experience to evoke the solidarity of humanity to promote mental health reform.

In October 2022, MHCN was awarded the tender for Department of Communities and Justice Disability Advocacy Futures Program (DAFP) for psychosocial disability systemic advocacy. MHCN delivers systemic advocacy through this project that includes liaising with advocacy providers, stakeholders, government and non-government decision-makers, and DCJ to improve understanding of the unique issues faced by people with psychosocial disability.

Overview

Mental Health Carers NSW (MHCN) welcomes the NSW Government's consultation on the Legislative Framework to Regulate Restrictive Practices and is pleased to contribute this submission to the consultation.

MHCN has consistently advocated for the elimination of restrictive practices, and we welcome legislation geared towards regulating these practices with the hope that this will reduce uses and make way for elimination. The principles guiding the regulation should be the rights articulated in the United Nations Convention on the Rights of People with Disability (CRPD), namely:

1. Article 15 – *Freedom from torture or cruel, inhuman, or degrading treatment or punishment* [1]
    a. This places the responsibility on the State to eliminate restrictive practices which limit freedom of movement and thought and can be used punitively.
2. Article 12 – *Equal recognition before the law* [2]
    a. People with disability must be supported to decide whether restraint may be used on them, rather than having it decided for them by substitute decision makers. The legislation must provide supports to enable people with disability and carers to make decisions.

MHCN has two particular concerns with the Legislative Framework as proposed. Firstly, we recommend that regulation of restrictive practices must be required in any setting within NSW where a service provider delivers a service. This includes out of home care, schools, medical and health facilities, corrections, disability services, and aged care.

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[1] United Nations Department of Economic and Social Affairs Article 15 - Freedom from torture or cruel, inhuman or degrading treatment or punishment available: https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-15-freedom-from-torture-or-cruel-inhuman-or-degrading-treatment-or-punishment.html

[2] United Nations Department of Economic and Social Affairs Article 12 – Equal Recognition Before the Law, available: https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-12-equal-recognition-before-the-law.html

Secondly, there are currently inconsistencies in definitions or regulations across these settings and there are unauthorized or unregulated practices in some settings. These practices can constitute abuse or violence in contravention of Article 15. Moreover, limiting this regulation to people receiving NDIS packages is at odds with Article 12 as it does not cover people with disability who may not receive NDIS packages yet still experience restrictive practices. Having NDIS coverage should not determine someone's rights.

We recommend that:

1. the proposed legislation should aim to address inconsistencies in definition and include currently unauthorised and unregulated practices.
2. that the legislative framework covers all providers in NSW who offer services to people with disability regardless of their NDIS eligibility.

Initial Comments:

1. States and Territories should ensure appropriate legal frameworks are in place in disability, health, education and justice settings, which provide that a person with disability should not be subjected to restrictive practices, except in accordance with procedures for authorisation, review and oversight established by law. **The Proposed legislation is unclear on how it protects people with disabilities where they are provided with services or care in setting other then those funded by the NDIS.**

2. The legal frameworks should incorporate the following requirements, appropriately adapted to sector-specific contexts:
    a. Restrictive practices should only be authorized:
        i. as a last resort, in response to a serious risk of harm to a person with disability or others, and only after other strategies, including supported decision-making, have been explored and applied; as the least restrictive response possible to ensure the safety of the person with disability or others; to the extent necessary to reduce the risk of harm and proportionate to the potential negative consequences from the use of restrictive practices; for the shortest time possible.
        ii. The use of restrictive practices should be subject to independent oversight and monitoring.
        iii. Decisions to authorise restrictive practices should be subject to independent review.
    b. It is not clear in the proposed legislation how the concept of independent review will be undertaken. The summary on page 10 suggests that independent review would be a reactive rather than a proactive process. That is, an independent review would only take place if there were a complaint. **The legislation should allow for proactive independent review.**
    c. The model also has considerable limitations on the independence of the Authorised Program Officers (APO) where the service provider appoints them. This may cause a conflict of interest. **The Legislation should specify mechanisms for the appointment of Authorised Program Officers that avoid real or perceived conflicts of interest from arising.**

d. As the RPA process is highly technical, should a person with disability wish to challenge it, **the legislation should clarify how they can do so fairly without reprisal or withdrawal of service**.
e. **The legislation provides no role for the Official Community Visitors and the NSW Disability Commissioner.** Their absence from this legislation is of major concern. Both the Official Community Visitors and the Disability Commissioner provide a mechanism for independent review that is superior to that of the Senior Practitioner and the APOs. However, this consultation paper does not allow for comments to made on this issue directly.

Consultation Paper Questions

Other Settings in which Restrictive Practices are Used

Questions

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

Out of home care settings should be covered by this legislation. Additionally, the legislation should clearly state that it covers all people who are in disability services, including those who are not covered by the NDIS. For example, there are people with psychosocial disability due to a mental illness who are not covered by the NDIS but live within a supported independent living facility or group home with people who are covered by the NDIS. It would not be appropriate or fair for the legislation to cover some but not all people living in the same facility and being provided the same services by the same provider. **The scope of the legislation therefore should apply to the service provider and extend to all the consumers/clients of that service, irrespective of their NDIS eligibility.**

Restrictive practices are likely to occur for people with mental illness who live in supported living. Results from a case study in Victoria demonstrates that almost all people who experienced restrictive practices were people with intellectual disability or acquired brain injury who lived in supported accommodation settings.[3] Moreover, it found that people with

[3] Webber et al. 2010. 'Restraint and seclusion of people on Compulsory Treatment Orders in Victoria, Australia in 2008-2009', *Psychiatry, Psychology and Law* 17(4): 562-573; Webber et al. 2012. 'The impact of the quality of behaviour support plans on the use of restraint and seclusion in disability services', *International Journal of*

autism, or psychiatric conditions and lived in supported accommodation were predictive of restrictive practices. **Given the link between having a cognitive and/or mental health disability, living in out of home care, and these being predictive of the use of restrictive practices, then the legislative framework should extend the coverage to these settings.**

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

The proposed legislation should cover the services provided to the recipient with a disability irrespective of where the service takes place. This may mean that there is overlap between this policy and policy and practices provided in some settings. For example, there are many people with psychosocial disabilities who from time to time are inpatients in a mental health facility. They continue to be NDIS clients while they are also inpatients. As inpatients, any restrictive practice will fall under the policies of the mental health system. **The Legislative Framework is unclear on how this legislation will apply to consumers in settings with a different regulatory framework covering restrictive practice.**

The legislation should cover the home of the person with disability where the disability service provider is providing disability services to the person within their own home. In these circumstances the restrictive practices may be implemented by the family members and not by the disability service providers, however, the legislation should cover the person if they receive disability services in any setting. This include people with a disability at home who are not in receipt of NDIS funded services but are provided with services by a disability service provider who also provides services under the NDIS. **That is, all consumers/clients of a disability service provider should be covered by this legislation irrespective of the setting and the source of funding.**

The framework should clarify whether it will cover the hospital emergency department particularly around the reporting of the use of chemical restraint. Events in emergency departments may meet the definition of chemical restraint if medication is used to control behaviour and assessment/treatment would not start until sedation has metabolised.

Positive Behavioural Support 2(2): 3-11; Chan et al. 2013. 'Examining the use of restrictive interventions in respite services in an Australian jurisdiction', *Psychiatry, Psychology and Law* 20(6): 921-931.

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?

Firstly, three different restrictive practices policies overlap: disability, aged care, and health. Restricting the question to aged care settings but not the health and mental health settings can cause confusion. There are minor but significant differences in some of the definitions of restraint and seclusion between the different policies, particularly between the mental health policies and this proposed disability policy. Clarity and consistency are needed to finesse these technical and definition differences.

This legislation should make clear that this legislation is applicable to people provided with disability services when they are in another setting such as health even when the restrictive practice is covered by the definition of the policies in the other setting. For example, the definition of seclusion in this legislation refers to confinement in a room. However, the definition of seclusion in the mental health legislation includes any place where the person is secluded and alone such as a courtyard or a section of the facility that includes several rooms.

MHCN recommends that this proposed legislation should make clear that if a person with disability and covered by this legislation is admitted to a hospital (or aged care facility) and is subject to a practice that meets the definition of a restrictive practice in that facility, it should be a reportable event under this legislation. In that way, any independent oversight is aware of all incidents of restrictive practices applied to a consumer wherever they are and wherever the restrictive practice occurred.

The Royal Commission into Aged Care Quality and Safety 2019 described restrictive practices in aged care as 'contentious' because, at the time, providers did not have to record or report restrictive practices. They now must trial and document alternative strategies prior to using restrictive practices. Regulating aged care providers under this legislation may allow for strategies that include psychosocial adaptation (e.g., using familiar staff to the person, providing sensory aids), and non-pharmacological approaches (appropriate staffing, pain management, and individualised care). This may promote

eliminating the use of restrictive practices unless "a last resort and utilising the least restrictive practice for the shortest period of time possible".[4]

Principles Governing the Use of Restrictive Practices

Proposals

- 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).
- 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.

Questions

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 6.35b?

Consistency is needed but not to the extent that it imposes undue burden on other service providers. The legislation should not provide onerous requirements on these services, for example for Health to provide information in a different format to that which they already use to report restrictive practices under their own policies. For example, a person with a disability may be admitted to an emergency department of a public hospital and subject to restrictive practices due to their behaviour. The hospital system already has a process for recording and reporting incidents of restrictive practice. This legislation should not require a duplication of that recording and reporting by the service simply to satisfy the requirements of this legislation. The Government will need to work closely with services to identify what reporting mechanisms they have already in place.

[4] Department of Social Services, 2014. *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector.*

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

The framework should ensure transparency around consumer and substitute decision making. Article 12 of the CRPD (Equal Recognition Before the Law) states that ascribing

> *"reduced mental capacity to a person living with psychosocial disability is not a ground for concluding that that person has no legal capacity to decide".*

Reduced mental capacity should not be a justification for using a supported decision maker to expedite processes because it is quicker. Supported decision making should be prioritised because it will decrease use of restrictive practices.

Prohibited Restrictive Practices

Question

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

The Appendix B – Prohibited Practices is appropriate; however, the legislation should specifically include a reference to prohibited practices that are declared by the government from time to time under government gazette. This list should be maintained by the Department, reviewed regularly, and publicly available.

Certain restrictive practices have additional risks. Prone restraint is dangerous and over-represented among reporting of restrictive practices.[5] The *NSW Restrictive Policy Directive* identifies prone restraint as incredibly risk and to be avoided, however it accounts for over half of reported uses of restraint in NSW LHDs.[6] It is dangerous and potentially deadly and, if not banned then at the very least it should be replaced by a lateral position (on side, airways open).

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[5] Leif et al. 2023. 'Stakeholders are almost always resistant': Australian behaviour support practitioners' perceptions of the barriers and enablers to reducing restrictive practices', *International Journal of Developmental Disabilities* 69(1): 66-82.

[6] Being, 2024. *Restrictive Practices – Report: A guide for people with psychosocial disability or mental health challenges.* https://being.org.au/10320-2/

Defining Restrictive Practices

Proposals

- Proposal 3: The NDIS definitions of restrictive practices should be adopted for the NSW legislative framework for restrictive practices.
- Proposal 4: The Senior Practitioner should have the power to issue guidelines, that are binding on service providers, that clarify how the definitions apply in different situations.

Questions

Question 7: Do you agree that:

- **The framework should use NDIS definitions of restrictive practices?**

The NSW Government should ensure that definitions of restrictive practice are consistent across all providers in NSW. These definitions should be contained in regulations under appropriate legislation. The legislation should refer to definitions of restrictive practices, but the actual definitions should be included in regulations rather than the Act to provide for ease of amendment.

The definition of seclusion should be reviewed to provide greater clarity on what constitutes seclusion and how it differs from environmental restraint. The definition of chemical restraint must be reviewed to enable overuse of medication to be included as chemical restraint.

Consistency across authorities is key as there are unnecessary differences in definitions between NSW Health, aged care, and disability sectors particularly around definitions of restraint (e.g., chemical). This causes confusion between sectors when decisions need to be made about whether restraint applies to a particular situation.

- **The Senior Practitioner should have the power to issue guidelines that clarify how the definitions apply in different situations?**

Restrictive practices versus reasonable adjustments need to be clearly identified and differentiated (e.g., as they do in Victoria). While the wording suggests the Senior Practitioner (SP) would be able to clarify restraints which do not fall within definitions of restrictive practices, the SP must also be able to identify what things might be misconstrued as

reasonable adjustments but are in fact restrictive. I.e., for people with psychosocial disability, it would be advisable for the SP to have access to OVP reps for health settings.

There is a need to more clearly define the difference between seclusion and environmental restraint. Allowances must also be made for practices that are appropriate in the circumstances, such as confining a person with an infectious disease to their room or a quarantine are without it having to be repeatedly reported.

The definition of chemical restraint is problematic as it allows for the use of medication that is used for treatment. This definition is so loose that it allows for the overuse of medication that is prescribed for a therapeutic purpose to then be extended to a form of chemical restraint. **The overuse of psychotropic medication is a form of chemical restraint, and this definition does not capture inappropriate overuse of medication.**

Behaviour Support Plans

Questions

Question 8: What role should the Senior Practitioner play in regulating Behaviour Support Plans? For example:

- **Should the SP have the power to prescribe additional and/or more detailed information for inclusion in the BSP? If so, what information?**
- **Should the SP have the power to require a behaviour support practitioner have certain qualifications and the SP's approval before they can prepare a BSP? If so, what should the additional qualifications and criteria for approval be?**

The concept of the Senior Practitioner prescribes a role that may be almost impossible to achieve. It is not clear from the proposed legislation how the SP will achieve oversight of all the behavioural plans and all the restrictive practice approvals across the system. **The Framework should be clearer on how the Senior Practitioner role will work in practice.**

There are concerns around the requisite skills and qualifications of behaviour support practitioners, and the methods considered suitable for BSPs. Self-assessment is a problematic entry point to a major clinical role. As behaviour support practitioners have a critical role in reducing restrictive practices and protecting/upholding the rights of people with disability, they must be appropriately educated, equipped, and supported to do so. Practitioners should have minimum tertiary education standard or verified coursework that

matches the required competencies for the BSP, professional training standard (internship, practicum) or should have an objective external assessment requirement.

There are no guarantees that behaviour support practitioners are independent especially in smaller communities or regional areas where demand outstrips supply and practitioners and providers may have close working relationships.

The framework needs better structure around the role of an 'independent person' to explain the restrictive process and the BSP. The legislation should provide a role for official community visitors to undertake an independent oversight role in this area independently of the provider.

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

The legislation should provide for a stronger role and involvement of family/carers/guardians in the development of BSP. A BSP should only be authorised by a qualified APO. They can be prepared by a behavioural support practitioner but can only be approved by an APO. If the self-assessment of behavioural support practitioners continues, there needs to be regulation around what level of proficiency the assessor has (core, proficient, advanced, specialist) relative to the level of BSP the individual needs. E.g., a core level assessor may be ill-suited to assess and develop a plan for a person with complex mental illness and disability. They must have demonstrable competencies required to manage the individual's BSP.

Government regulatory barriers should be considered. If medication is the restrictive practice, the behavioural support practitioner may encounter difficulties with the prescribing professional not wanting to reduce the practice or unwilling/time-poor/unable to do so. Practitioners may be reluctant or wary to reduce restrictive practices because other methods (e.g. positive behaviour support) are time and labour-intensive (e.g. RPs are quicker and easier) or may be seen as less proven to be effective.

Authorised Program Officers

Proposal

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.

Questions

Question 10 (Authorised Program Officers employee or consultant to the NDIS provider who has training in behaviour support): Should APOs be empowered to either:

- **Authorise particular categories of RPs without separate Senior Practitioner authorisation (a partially delegated model)? If so, what categories of RPs should be able to be authorised by APOs? Should these be prescribed by legislation, or through class and kind orders?**

The role and practice of the APOs and behavioural support practitioners is confusing. It could be argued that the APOs should be under the supervision of the Senior Practitioner rather than employees of the service provider.

- **Provide preliminary approval of RPs, with final authorisation provided in all cases by the Senior Practitioner (a two-step model)**

This depends on the type of restrictive practice used. Seclusion, physical, and mechanical should be two-step to avoid it unless absolute last resort (i.e., all other methods have been attempted, reported, and documented). There are risks as certain practices may be used in situations perceived by staff to be acute but may not be appropriate. Staff must be adequately trained and with sufficient personnel on shift to understand different types of behaviours to avoid using a restrictive practice where a de-escalation method would suffice.

An unstated assumption in the Framework is that restrictive practice can be anticipated and included in a BSP. However, the legislation needs to cover more clearly those situations where the behaviours is not anticipated and there is no RP included in a prepared BSP.
Proposal 12: The legislation should more clearly state the process for authorising, actioning, recording, and reviewing, RPs which are not included in a BSP and are in response to unanticipated behaviours.

- **What would be the benefits and risks of the above models?**

The two-step model risks duplication but might be effective in reducing how quickly certain restrictive practices are used when situations are perceived incorrectly as acute or severe.

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

There are opportunities to bring families and carers into identifying areas for improved supported decision making in assessment processes. Families and carers, like people with disability, may be subject to pressure from services to consent to practices out of fear of service withdrawal. While the current authorisation policy does not include family members, families and carers can be involved in supporting their loved one to express their will and preferences and develop their decision-making capacity.[7] Families and carers are powerful advocates and sources of information but there must also be recognition of potential conflicts of interest.

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?

Single employment of an APO may present barriers to smaller providers but beneficial to larger providers. Consulting on several providers may cause conflict of interest. The Senior Practitioner being able to audit and review decisions may help mitigate this.

[7] Then, S-N. 2024. 'Supported decision-making and the Disability Royal Commission', *Research and Practice in Intellectual and Developmental Disabilities* 11(1): 86-106.

Duration of Authorisation

Proposals

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

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.

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

Questions

Question 13: Do you support the proposed duration of authorisation (12 months) and emergency use proposals for RPs?

This procedure seems similar to the 'interim authorisation' process that the emergency uses procedure seeks to replace. The interim authorisation risked lack of expertise because it was approved by the senior manager of the NDIS provider. The emergency uses process seems to also be up to the discretion of the provider and they simply must notify the APO as soon as possible. It is unclear what the differences are between the two and what 'as soon as possible' entails.

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

This depends on whether the Senior Practitioner will have access to the provider's history of using restrictive practices. Can they determine that a provider has used restrictive practices

too much without demonstrating sufficient alternative techniques or if they have a history of non-compliance? Further explanation is needed.

Independent Review Rights

Proposal

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

Questions

Question 15: Should authorisation decisions:

- **Be open to review?**
- **Be reviewable at NCAT?**

MHCN recommends that an **electronic system for the development and storage of behaviour support plans, authorisations and recording of restrictive practice** events could be centrally developed by the Department of Communities and Justice and made available to all disability service providers.

Subject to privacy and confidentiality provisions, an electronic system has the potential to provide for review by authorised stakeholders and provide a consistent and simple method of monitoring and evaluation.

There also need to be avenues for people with disability, families, carers, and kin to raise their concerns and complaints and have those concerns and complaints linked to records of RP and subject to independent review.

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?

The rights to seek a review of BSP, authorisations for restrict practice and the records of restrictive practices applied under the BSP and outside the BSP, **should be available to the person's principal care provider and the Official Community Visitors**. The concept of a

designated carer/principal care provider as included in the Mental Health Act provides a model for the identification of a person and how they should have the right to review behavioural plans and approved restrictive practices.

The role of **official community visitors could be extended to include an external review process** to satisfy themselves that the rights of the consumer and the carers/families are being maintained. The official visitors could be required to review behavioural plan and restrictive practices when visiting. This is not to critique or approve the plans but to satisfy themselves that the provisions of the Act that protect consumers rights are being met.

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

- Yes.

Complaints Handling and Investigations

Proposals

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.

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.

Questions

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

There should be a process of routine and continually monitoring of the use of restrictive practices. There may be instances where individual does not understand they can make a complaint or know the RPs are being used, or that the provider has not sought other behaviour support measures in the BSP before applying the restrictive practice/s.

What is missing from this proposal is the reporting process to the Senior Practitioner on the frequency and type of restrictive practice used by providers. There is a need for continual data collection and analysis to identify trends and practices across the system, which should be used as part of a public reporting system.

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

Yes. If they can enter the premises for investigation, they can identify potential misuse and non-compliance. However, the official community visitors already have the power to enter the premises, and this capacity should be incorporated into the monitoring process for these proposals.

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

There needs to be clarity around how it currently works with the NCAT complaints process and whether there is there an existing model that could be applied or adapted.

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?

- NSW Disability Commissioner
- Australian Human Rights Council
- NCAT
- NDIS Commission (to investigate provider and pursue deregistration if in breach)
- Law enforcement (to investigate breaches and violation of legal/human rights)

Reporting

This Paper has already proposed a number of means by which the Senior Practitioner could have visibility over the use of restrictive practices:

- The Senior Practitioner would be aware of all authorisations, either by giving them or, in a partially delegated model, by the APO being required to inform the Senior Practitioner of authorisations it has given (see section 5.3 above),
- The Senior Practitioner would audit APO decisions in a partially delegated model, and

- The provider would be required to report on a monthly basis to the Senior Practitioner on any uses of restrictive practices before a BSP has been prepared and authorisation given.

Question

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?

There should be a compulsory, electronic reporting system developed across the sector to enable the SP to monitor the use of restrictive practices at each agency providing services to people with a disability.

Education and Guidance Functions

Proposal

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 practice and behaviour support planning.

Question

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

In principle, but information must be developed alongside people with disability, lived experience of mental illness, their carers, and families and via peak advisory organisations and disability advocacy providers.

Liability

Question

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?

Currently they may be registered or receive civil penalty. If an unauthorised restrictive practice violates criminal law, there needs to be more information and clear guidelines around what consequences they will face.

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?

There is insufficient explanation around what constitutes 'good faith'. Is it a matter of staff thinking the restrictive practice was necessary or does it require having tried and demonstrating application of alternative strategies in the BSP? If the family member/carer does feel the RP was excessive/overmedication, will there be recourse for them to have this investigated before immunity is granted?