Ageing and Disability Commission

NSW GOVERNMENT

NSW AGEING AND DISABILITY COMMISSION

SUBMISSION ON A LEGISLATIVE FRAMEWORK TO REGULATE RESTRICTIVE PRACTICES

March 2025

Background

The NSW Ageing and Disability Commission (ADC) was established on 1 July 2019 with the objectives of protecting older people and adults with disability from abuse, neglect, and exploitation, and protecting and promoting their rights.

A key role of the ADC is to respond to reports about older people (65 years and over or, if Aboriginal and/or Torres Strait Islander, 50 years and over) and adults with disability (18 years and over) in NSW who are subject to, or at risk of, abuse, neglect and exploitation in their family, home and community.

We also oversight and coordinate the Official Community Visitor (OCV) scheme in NSW. OCVs are independent Ministerial appointees who visit accommodation services where an adult with disability, older person, or child in care is in the full-time care of the service provider; and assisted boarding houses.

Our submission has been informed by our work in handling reports about abuse, neglect and exploitation, including those involving the use of restrictive practices, and issues relating to behaviour management and restrictive practices identified by OCVs in their visits to NDIS participants living in disability supported accommodation and children living in residential out-of-home care (OOHC).

Key views

The ADC welcomes consideration of a legislated framework for regulating restrictive practices in relation to people with disability in NSW. Overall, we are keen to see a framework and approach that:

- provides a strong focus on improved outcomes for individuals with disability, and the elimination and reduction of the use of restrictive practices
- is proportionate, taking into account factors including the nature and impact of the proposed restrictive practice
- enables better alignment with states, territories and the Commonwealth, and reduces duplication
- supports effective information sharing and actions by the relevant agencies.

We understand that the NSW Council for Intellectual Disability has proposed that key aspects of the development of a legislative model in relation to restrictive practices in NSW should be informed by a working group, similar to the approach used in relation to guardianship reform recommendations. We found the latter working group to be a constructive process and would support a similar approach being taken in relation to restrictive practices, noting the complexity of the issues and the significant impact on people with disability.

Settings covered by the proposed legislative framework

The ADC supports there being a clear legislative framework(s) for regulating the use of restrictive practices in relation to people with disability across sectors, including disability support, OOHC, education and health services. However, we consider there is a need for a staged approach.

In our view, the initial focus should be the provision of disability services, but the legislation should provide for other sectors or agencies to be able to be prescribed by the Senior Practitioner (or agency responsible for operating the restrictive practices authorisation model) to come under the framework as and when deemed appropriate.

Such a staged approach would align with the position of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (DRC) and enable the Senior Practitioner (or relevant operating agency) to:

- embed the legislated restrictive practice authorisation approach and safeguards in the existing sector and iron out any significant issues before exploring the addition of other sectors
- undertake work with the relevant sectors, including assessment of their compliance with the principles, the arrangements they currently have in place relating to the use of restrictive practices, and clarity about volume and areas of duplication, to better inform the actions required
- learn from the experience of other states and territories in relation to these sectors (for example, the incorporation of forensic/ mental health services in Victoria).

There is a high risk that incorporating all (or many of) the proposed sectors at the outset would flood the Senior Practitioner with matters, rendering them ineffectual and providing a safeguard in name only.

Aged care services

We are keen to see greater alignment between restrictive practice authorisation requirements and approaches across sectors, including across disability and aged care services. Consistent with our feedback on the draft Aged Care Bill, we consider that there is a need for further work to reform the arrangements for the authorisation and use of restrictive practices across disability and aged care services, including to:

- ensure alignment in the approaches, noting key similarities in the populations, including a high proportion of older people with disability in aged care
- enhance safeguards and outcomes for individuals
- reduce and streamline administrative requirements, informed by a risk proportionate approach.

Principles governing use of restrictive practices

The ADC supports the proposed guiding principles and agrees that the principles should apply across the identified settings.

However, we would also welcome the inclusion of additional principles that more strongly reflect a person-centred approach, recognising the infringement restrictive practices impose on to an individual's human rights, dignity, and agency. In our view, the principles should include requirements relating to:

- involvement of the person with disability in the development of behaviour management responses and, to the maximum extent possible, active involvement in decision-making in relation to behaviour support plans (BSPs)
- regular review of the use of restrictive practices (strengthening the existing principle that restrictive practices should only be used for the shortest time possible).

We agree with Proposal 2 that the legislation should require government agencies in the health, education and justice sectors to annually report to the Senior Practitioner on their, and their contractors', compliance with the principles. The legislation should provide for the Senior Practitioner to prescribe the data and other information the agencies are required to provide.

However, the sole focus should not be on provision of the annual report and compliance. It

is imperative that:

a) the role of the Senior Practitioner includes providing education and support to enable constructive and positive work with the relevant agencies to meaningfully strengthen practice and safeguards, with a focus on outcomes for individuals and improvement in relation to the elimination and reduction of the use of restrictive practices

b) the legislation provides for the Senior Practitioner to proactively and regularly obtain relevant information from the agencies to inform its work, via effective information sharing arrangements and/or ability to require the provision of information.

It is important to ensure that the Senior Practitioner obtains the critical information it needs to effectively monitor and assess compliance with the principles; identify and analyse trends, gaps, practice issues, and areas for targeted actions and improvement; and ascertain whether, and at what point, the relevant sector should be prescribed to come under this restrictive practice authorisation model. Requests or notices of requirement by the Senior Practitioner for the provision of information would take into account what is reasonably necessary for fulfilling its role.

Prohibited practices and defining restrictive practices

We consider that the legislation should prohibit the use of certain restrictive practices and agree that this should align with the practices identified by the Disability Reform Council in 2019, noting this was also supported by the DRC.

The ADC also supports the adoption of the NDIS definitions of restrictive practices and the Senior Practitioner having the ability to issue guidelines that clarify how the definitions apply in different situations.

As much as possible, we are keen to see a consistent approach across the Commonwealth, states and territories to minimise confusion, provide a national approach, and avoid duplication.

As previously stated, the ADC supports NSW CID's recommendation for the formation of a working group and consider that this group could help inform the definitions in the legislation. When the Senior Practitioner is introduced, their work and guidance material should be informed by people with lived experience, ideally through an advisory committee. This would be an important step in placing the voice of people affected by the implementation of restrictive practices at the forefront.

Regardless of the functions of the Senior Practitioner, a comprehensive information and education campaign(s) will be essential, both ahead of commencement of the legislation and on an ongoing basis. The campaign should target people with disability and their families, carers, supporters, and those working in relevant sectors. Among other things, it will help stakeholders to better understand the Senior Practitioner's role and how it differs from that of the NDIS Quality and Safeguards Commission.

Senior Practitioner role in regulating behaviour support plans

The ADC supports the Senior Practitioner having a role in regulating BSPs. OCVs have consistently reported problems with the quality of BSPs in relation to people with disability living in NDIS supported accommodation in NSW, such as plans lacking knowledge about the participant and their needs, not being regularly reviewed, including outdated and unnecessary restrictive practices, and not including fade-out strategies.

The ADC is aware of the varying experience of behaviour support clinicians and the impact this can have on the person with disability. Poor or inadequate BSPs can have a snowball effect, including an over-reliance on more complex and intensive practices, especially where there has been a mismanagement of behaviours and failure to address core underlying issues. This has a significant impact on the person and their quality of life, leading to physical and mental health impacts, which can in turn result in destabilisation of their accommodation, supports and social connections.

We consider that the Senior Practitioner should have the authority to prescribe additional information to be included in the BSP, including:

- information detailing how the person and their supporters (including guardian, family, friends, advocate) have been consulted and supported through the decision-making of the BSP, and how this has informed the development of the BSP
- evidence to indicate that all possible positive behaviour strategies have been attempted and the restrictive practice(s) is a last resort
- data to support the monitoring and evaluation of practices
- evidence to indicate that:
  - the cultural and language needs of the person have been considered and incorporated
  - possible causes of the person's behaviour have been explored and addressed or ruled out (for example to show the behaviour is not associated with a medical issue or pain)
- details of how the BSP will be monitored, reviewed, and adjusted where needed.

The ADC supports the legislation providing for the Senior Practitioner to require a behaviour support practitioner to have certain qualifications and the Senior Practitioner's approval before they can prepare a BSP that will be used to authorise the use of a restrictive practice.

We recognise that there are various relevant qualifications that current behaviour support practitioners have, such as occupational therapy or psychology. The ADC does not see a need to limit qualifications to a specific professional background, rather the emphasis should be on the establishment of robust accreditation criteria and an assessment process that would be used to determine if an individual has the required competencies to be approved as a behaviour support practitioner. We consider that the qualifications and criteria should include (but not be limited to):

- evidence of relevant experience working in the sector, including working with people with disability
- assessment of capability to assess behaviour support needs and create behaviour support plans, including understanding of and ability to use various assessment tools and approaches
- appraisal of their understanding of the fundamentals of behaviour support.

Research[1] supports the need for the development of accredited and evidence-based training that builds capabilities in a way that is relevant to the needs of people with disability while also catering to the professional development needs of those undertaking the training. The qualification process should include such training to ensure an understanding of the principles, human rights, and ethics around restrictive practices, in

[1] Hall, J. R., Newton, D., McVilly, K., McKay-Brown, L., Hayward, B., February 2025. "How we might best develop and deliver training and professional development in positive behaviour support: A systematic review." Journal of Policy and Practice in Intellectual Disabilities. https://onlinelibrary.wiley.com/doi/10.1111/jppi.70002

addition to the policy and legislative environment in which it occurs.

For approved behaviour support practitioners, there should be ongoing mandated 'Continuing Professional Development' (CPD) and an agreement to follow a code of conduct in relation to their practitioner role.

Authorisation model

The ADC is keen to see a proportionate approach to the authorisation of restrictive practices that increases the emphasis on meaningful, positive and tangible outcomes for people with disability and takes into account the nature and impact of the proposed practice.

In terms of authorisation models, we generally do not support the 'two-step' model due to (among other things) duplication and the impracticality of this approach in the context of significant volume – except for where it occurs as part of a 'class or kind' determination. While we are open to consideration of a model involving a panel with representation by an independent behaviour support practitioner (independent specialist), we note that it currently involves substantial and ongoing investment of time and resources by the operating agency (DCJ) to manage and support this approach. There is a question as to whether there has been an adequate return on this investment in relation to the change and positive outcomes that were intended.

In relation to a partially delegated model involving a Senior Practitioner and Authorised Program Officers (APOs), if used we believe there should be a proportionate risk-based approach to determining which restrictive practices should be authorised by the Senior Practitioner and which should sit with an APO. In our view, the proposed working group would provide helpful guidance to inform the criteria or categories that would usefully differentiate high-risk restrictive practices that require authorisation by the Senior Practitioner and practices that could be authorised by the APO. The categories/ criteria should not only account for the type of restrictive practice but also consider the complexity, intensity, and the individual's physical and mental health needs. It is important that restrictive practices are authorised and used appropriately, in line with the agreed principles, while also enabling the Senior Practitioner to focus on higher risk matters or practices and the delivery of its broader systemic and practice improvement functions to support meaningful change.

Overall, we support the legislation providing for the Senior Practitioner to make 'class or kind' orders/ determinations. There are a number of ways this could work in practice, including to:

- require certain restrictive practices to be authorised through a particular way(s) – such as to require a type of restrictive practice to be authorised by the Senior Practitioner
- specify requirements for a particular provider and/or APO – such as where the provider is new and supporting people with complex needs; where one APO is operating across multiple providers; where there are identified issues relating to the use of restrictive practices or their authorisation in a particular service or involving a particular APO; or where a provider or APO has a proven positive track record.

We agree that 'class or kind' orders would provide a more responsive and nuanced approach. Importantly, many of these orders would be informed by the broader work and functions of the Senior Practitioner. We envisage that the Senior Practitioner would use 'own motion' powers, informed by external and internal intel to randomly audit and review APO authorisations (such as authorisations by a particular APO/provider; authorisations by

APOs in a particular geographical area; authorisations of a particular type of restrictive practice, etc), and have the ability to take action where any issues were identified. This could include remedial action/education; removal of the approval of an APO; referral of information to the NDIS Commission or other relevant agency; penalties; and/or a 'class or kind' determination requiring all authorisations by an APO to also be authorised by the Senior Practitioner (until improvement or other action). We consider that the above approach may also help to mitigate the conflicts of interest inherent in APOs being employed or engaged by the provider seeking to use the restrictive practice.

This approach should also be supported by:

- a quality assurance framework that embeds rigorous scrutiny of authorisation
- mandatory training and approval of APOs by the Senior Practitioner, with the requirement of regular mandatory learning of modules endorsed by the Senior Practitioner
- all APO decisions to be notified to the Senior Practitioner, including flagging of contentious decisions
- structured delegation of decision-making with clearly defined levels of responsibility and what can and cannot be authorised by an APO, supported by clear and precise guidance material
- reviewable decisions of the APO and Senior Practitioner, complemented by a complaints mechanism
- application of legislated penalties.

The Senior Practitioner should have the legislative power to conduct individual and systemic inquiries and reviews. This would enable the Senior Practitioner to examine individual cases, identify broader trends, and analyse relevant data, ensuring that their work and resources are focused where they are most needed. The ability to investigate practices, identify patterns, and make informed decisions on where to direct attention will support actions to address systemic issues, identify service gaps, and make necessary improvements across various sectors.

In our experience, regardless of the model, it will be important to ensure that adequate funding and resourcing is provided to both appropriately establish the model and support its long-term sustainability and effectiveness. The operating agency must be equipped with the necessary resources to function effectively over time, taking into account current and future growth. Without this support, the Senior Practitioner or operating agency will not be able to navigate the complexities of its role, address emerging challenges, or drive the systemic change needed to reduce and eliminate the use of restrictive practices.

It will be important to review the resourcing and operational needs of similar bodies in other states and territories to clearly identify the resources and structure required to make the model effective.

Duration of authorisation

The ADC supports the proposed duration of authorisation proposals for a maximum of 12 months. There should be clear guidance and criteria for how timeframes are set and evidence supporting the selected timeframe, including the views of the person with disability. However, there should be provision to require reviews at shorter intervals in certain situations – for example, where there is higher complexity or risk to the person with disability.

We do not object to the inclusion of an emergency use process. However, there would need to be clear guidance and definitions in the legislation regarding when it is permissible

to use restrictive practices in an emergency, to avoid misinterpretation or misuse. This should include specific details on how often and under what circumstances these practices can be used, such as defining what constitutes an 'imminent' risk and what that looks like for the individual. Strict legislated timeframes for informing the Senior Practitioner should also be included, as terms like 'notified without delay' could be broadly interpreted, and penalties should apply for failure to comply with the legislated requirements. These elements could be shaped by the working group suggested by NSW CID.

We agree with the proposal that the Senior Practitioner should have the power to cancel an authorisation of restrictive practices. Beyond the circumstances listed in the consultation paper, this should include where the APO has contravened a provision of the legislation (for example, to cover situations in which the APO is employed by one provider but provides authorisations across more than one service in a rural area).

Independent reviews

The ADC supports the legislation providing for the person with disability, or a person concerned for their welfare, to seek a review of the decision to authorise or not authorise a restrictive practice. A procedurally fair process like section 53 of the *Administrative Decisions Review Act 1997* (NSW) would ensure clear guidance, such as who could conduct an internal review and associated timeframes. This Act also speaks to the right to seek an external review with NCAT, which offers another level of independent review. Consideration would need to be given to whether this process is sufficiently accessible to the person with disability impacted by the restrictive practice (for example, the existing requirement for review applications to be in writing).

In developing this pathway, a range of considerations need to be taken into account, such as whether a person can seek a stay of the decision; whether 'emergency use' practices will be allowed while a review is being undertaken; whether the restrictive practice can continue while the review is being undertaken in circumstances where the person who is subject of the restrictive practices has sought a review and significantly objects to the restrictive practice; and whether a party can bypass the internal review and go directly to NCAT, and under what circumstances. These considerations and processes would be best explored by an expert working group.

There should be clear accessible information provided to the person and their supporters to inform them of their right to seek a review and information explaining the review process.

We recognise that the involved service providers have a vested interest in the restrictive practices being authorised and there is a risk that they could inappropriately use the review process to delay actions by the Senior Practitioner or to continue using the practices pending the outcome of the review(s). However, we consider that this risk could be mitigated by legislative requirements as to the criteria that would need to be met for the provider to apply for a review of the decision (for example, that specific information or evidence was not considered in the original decision), and by enabling the decision to stand pending the outcome of the review.

The right to request the service provider review the BSP at any time

Given the impact of restrictive practices on the person with disability and the settings and circumstances in which the practices are implemented, it is important that the person is offered opportunities to seek a review of the BSP and/or to make a complaint. The opportunity to request a review of the BSP should be available at any time as the person's circumstances may change necessitating a review. Within this process, it should be mandatory for the behaviour support practitioner and implementing service provider to

inform the person of their rights in a way that is meaningful to the person, including involving their supporters in this process. This should occur during various points of the BSP, such as the consultation and development stage, implementation, and review. It should also be documented to evidence the occurrence.

Complaints handling and investigations

It is important that a complaints and investigation function is part of the proposed framework.

The ADC supports the Senior Practitioner having the power to investigate the use of restrictive practices and the quality of behaviour support planning, on receipt of a complaint or on its own motion. It is vital that the Senior Practitioner has 'own motion' powers in relation to complaint handling and investigations to enable appropriate and effective use of information holdings acquired through its varied legislated functions, and intelligence received from external parties. It would not be reasonable to limit the Senior Practitioner to conducting investigations or inquiries only in response to complaints, particularly as most people with disability affected by restrictive practices, and their supporters, do not tend to make complaints, for a multiplicity of reasons that were well elucidated by the DRC.

We agree that the Senior Practitioner should have powers to respond to inappropriate practice, including the misuse of a restrictive practice. We support the response options identified in Proposal 11 – that is, to enable the Senior Practitioner to direct the provider to do/cease doing something; to cancel an authorisation; and to refer to matter to the NDIS Commission or other relevant entity. However, it is important to recognise that other relevant actions by the Senior Practitioner could include removing approval of an APO (it is not clear if this would be intended to come under the scope of its directions to the provider).

Information sharing and reporting

To facilitate efficient and effective responses to concerns, and to minimise duplication, the legislation should include information sharing provisions with relevant agencies and entities. This would include agencies such as the NDIS Commission, the NDIA, the ADC (including the OCV scheme), NSW Health, NSW Police, Education, DCJ (OOHC), the OCG, and other regulatory bodies.

It is vital that the Senior Practitioner and NDIS Commission can proactively share information relating to the regulation and use of restrictive practices. This should not be limited to sharing information following an investigation – the legislation needs to provide for the effective sharing of relevant information to support the exercise of the respective agency's functions. Information sharing between the two agencies can also reduce the likelihood of efforts that are duplicative, at cross-purposes, or that put an unnecessary administrative burden on providers, including reporting requirements.

The Senior Practitioner should have the ability to require the provision of information in certain circumstances, including as part of its investigative powers, and to enable information to be obtained from the relevant NSW Government agencies that are required to comply with the principles.

In terms of sharing information, we also consider that regular and public reporting by the Senior Practitioner of key data and trends relating to its functions and restrictive practices will be vital to support transparency and accountability, improve practice, and drive change.

Education and guidance functions

As mentioned earlier, it is imperative that the role of the Senior Practitioner includes providing education and guidance, including the development of clear and precise guidance for stakeholders. This will support standardisation and best practice, help to embed the principles, and provide tools and resources to providers to build their capability, while ensuring compliance and accountability.

The Senior Practitioner should be in a unique position to use data and insights from its oversight of BSPs to develop targeted education and information campaigns. Accessibility of the information and messaging is also critical.