NEW SOUTH WALES
BAR ASSOCIATION

Our ref: DIV25/350

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Mr Mark Follett
Executive Director
Policy Reform and Legislation Branch
NSW Department of Communities and Justice

By email: [redacted]

Dear Mr Follett,

Consultation Paper: A legislative framework to regulate restrictive practices

1. The NSW Bar **Association** thanks the Department of Communities and Justice (**DCJ**) for the opportunity to provide a submission in response to its **Consultation Paper** titled "A legislative framework to regulate restrictive practices" on people with disability.

Introductory comment and summary

2. By way of introductory comment, the Association recognises that while restrictive practices may be used in some circumstances, there are concerns that such practices can also be imposed as a means of coercion, convenience or retaliation by staff, family members or others providing support and that such practices may infringe a person's human rights. Both the general community and human rights groups have expressed significant concerns about the use of restrictive practices. For example, the United Nations Committee on the Rights of Persons with Disabilities (UNCRPD) has stated:

> "*… is concerned that persons with disabilities, particularly those with intellectual impairment or psychosocial disability, are subjected to unregulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraints and seclusion, in various environments, including schools, mental health facilities and hospitals.*
> *The Committee recommends that the State party take immediate steps to end such practices, including by establishing an independent national preventive mechanism to monitor places of detention—such as mental health facilities, special schools, hospitals, disability justice centres and prisons—in order to ensure that persons with disabilities, including psychosocial disabilities, are not subjected to intrusive medical intervention*"[1]

3. As a result, the Association's view is that that any proposed legislative framework to regulate restrictive practices in NSW needs to be implemented only after (i) extensive consultation with all relevant stakeholders, and (ii) careful and thorough analysis with a general recognition that such measures should always be a last resort measure and used only to prevent harm.

4. This submission provides feedback to some, but not all, of the questions contained in DCJ's Consultation Paper The Association's decision not to provide comment in response to certain proposals should not be interpreted as either agreement or disagreement with those proposals.

[1] Committee on the Rights of Persons with Disabilities, 'Concluding Observations on the Initial Report of Australia, Adopted by the Committee at Its Tenth Session (2-13 September 2013) (United Nations, 4 October 2013) [35]-[36].

General comments as to restrictive practices in NSW courts and tribunals

5. The Association's members are regularly involved in disputes involving allegations of abuse and mistreatment of people with disability. These disputes often arise in the Supreme Court of NSW (Protective List) and in the NSW Civil & Administrative Tribunal (Guardianship Division) (**NCAT**). Members are also involved in various hearings before NCAT where guardianship orders relating to restrictive practices are considered.

6. In 2023-2024, the number of people living with dementia and other age-related decision-making disabilities was the primary driver of growing workloads in the Guardianship Division of NCAT. Dementia accounted for 41% of all applications made to the Guardianship Division of NCAT, followed in turn by intellectual disability (18% of applications); mental illness (14% of applications); neurological conditions (7% of applications); brain injury (6% of applications); and drug and alcohol related conditions (0.2% of applications).[2]

7. In the Association's view, DCJ should consider '*restrictive practices*' cases in both these jurisdictions. Restrictive practices aim to address behaviour issues and minimise harm; they do not aim to treat a medical condition. For that reason, they are not considered a form of medical treatment under the *Guardianship Act 1987* (NSW)

8. The *Guardianship Act* governs when NCAT may make a guardianship order. Before appointing a guardian with a restrictive practices function, the Tribunal considers:

    - The views of the person about the proposed practices;
    - The current behaviour support plan which should include:
        - A summary of the history of the behaviour;
        - An assessment of the impact of the behaviour on the person and others;
        - Any positive approach is taken to address the behaviour, or being considered;
        - The restrictive practices proposed.
    - Evidence from the person's family and friends;
    - Evidence from the person's treating medical professionals, carers and disability support service providers;
    - Any consultation with relevant specialists;
    - If chemical restraint is proposed:
        - Medical evidence about the person's diagnosis;
        - The nature of the chemical restraint proposed;
        - How and when the medication will be used;

[2] NSW Civil & Administrative Tribunal (Annual Report 2023-2024), page 43.

- Any possible side effects.

- Whether the person's behaviours can possibly be managed without using restrictive practices;

- Whether the practice has been approved by an authorisation process, if required.[3]

9. Guardianship orders, including those which provide a restrictive practices function, are subject to periodic review in NCAT. In addition, a person with a genuine concern for the person can request a review of a guardianship order at any time.

10. The Association notes that the NCAT process, therefore, considers a wide range of evidence before making orders in relation to restrictive practices. In the Association's view, it would be useful if there is broad consultation with the Senior Members of NCAT to ensure there are no inconsistencies between a new legislative framework to regulate restrictive practices and the decisions of NCAT. Any inconsistency would cause difficulties for people with disability, their family members and support people. Additionally, inconsistencies between the national scheme and state legislation would be problematic.

11. Some recent NCAT cases include:

- *HZC* [2019] NSWCATGD 8
- *TZD* [2021] NSWCATGD 14
- *JUW* [2023] NSWCATGD 3
- *SKN* [2023] NSWCATGD 16.

Scope of the proposed legislative framework

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

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

12. DCJ's Consultation Paper proposes that the legislative framework for regulating restrictive practices would apply to the disability service provision, health, education and justice settings. In the Association's view, this legislative framework should be applied broadly, including in out of home care settings.

13. In all relevant settings, the proposed legislative framework should not only apply to NDIS participants, but to all persons with disability. Paragraph 3.2 of the Consultation Paper, in the context of disability service provision states that the legislative framework would apply to NDIS participants, rather than people with disability. Further, Proposal 1[4] in DCJ's Consultation Paper indicates that, in disability service provision, health, education and justice settings, the proposed legislative framework would **only** apply to NDIS participants, rather than to all persons with disability. The Association seeks greater clarity about whether this is DCJ's intention in developing the proposed legislative framework and the reasons for that position

[3] NCAT Fact Sheet – Guardianship Division, Restrictive Practices and Guardianship (June 2024).

[4] Proposal 1 states: "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)" (*emphasis* added).

14. If the intention is that the legislative framework would only apply to NDIS participants, this is of concern to the Association The United Nations Convention on the Rights of Persons with Disabilities is applicable to *all* persons with disability. If the legislative framework were to be limited to NDIS participants only, it may unfairly discriminate people with disability who are not NDIS participants.

15. Furthermore, it is important to recognise that not all persons who are NDIS participants have a funding package as a part of their NDIS Plan that provides for a Behaviour Support Practitioner (**BSP**). As an example, persons who have a serious mental illness may not have a BSP, due to the episodic nature of their condition.

Justice settings

16. In the context of justice settings, it is conceivable that there may be people with a disability in NSW prisons who are not participants of the NDIS. If the proposed legislative framework were to apply only to persons with a disability who were NDIS participants in the NSW prison system, then that will inevitably raise a number of issues and challenges. In addition to the proposed legislative scheme being potentially discriminatory to those persons with a disability who are not participants of the NDIS, it may also lead to unintended consequences for other inmates and detainees who are subjected to restrictive practices, such as segregation. Given the objectives of the proposed changes that result could lead to unintened situation.

17. At present, if a person with a disability in prison requires a guardian as a result of a decision-making disability (and they otherwise satisfy the requirement for the appointment for a guardian pursuant to the *Guardianship Act*), then an application could be made to NCAT. Under the relevant legislation,[5] NCAT could make orders for restrictive practices to be applied. Although, it is important to note that if NCAT is considering whether to include restrictive practices as a part of any order, it must join the Public Guardian of NSW into the hearing for their views (typically the Duty Guardian participates). Guardianship Orders are reviewable and can be revoked or varied.[6]

18. A person with a disability in prison who is also a NDIS participant does not, at a practical level, have the same oversight or assistance while they are in prison that they would receive when they are in the community, particularly in regards to the use of restrictive practices.

19. It is important to bear in mind that, in NSW prisons, there is a division of responsibility between different health services. For example, Justice Health & Forensic Mental Health Network (**JHFMH**), a government statutory body, is responsible for the provision of healthcare, including psychiatric care for persons in prison in NSW. However, JHFMH do not provide psychological services. Those services are provided by the Corrective Services NSW (**CSNSW**).

20. In practical terms, this arrangement may create confusion between healthcare providers and CSNSW employees. This can result in a range of complications, including a lack of continuity of care and privacy/information sharing issues. If a further body, such as a Senior Practitioner, became involved, it has the potential to further complicate and potentially frustrate the process.

21. For those persons with a disability in prison who are also NDIS participants, it may also create further challenges when the person is ultimately released to the community and transferred back to the responsible Behaviour Support Practitioner under their own NDIS Plan. Often on release, particularly where the person is to be supervised on parole or some other court order, there is limited information-sharing and

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[5] *Guardianship Act, ss 4, 14(1), 15, 16(1), 17.*

[6] *Guardianship Act, s 18, Division 4 generally,*

provision for stakeholder meetings regarding the person concerned, which can contribute to lack of compliance with court orders, therein exposing the person to breach action.

22. At present, persons in prison can be subject to certain types of restrictive practices provided for in the *Crimes (Administration of Sentences) Act 1999* (NSW), such as "segregation". Segregated inmates are required to undertake certain additional mental health checks at certain intervals. Those practices have their own existing review processes. For example, an application can be made to the Serious Offenders Review Council for review of the segregation. Similarly, a person could be placed on a "RIT" (Risk Intervention Team).[7] As part of this process, CSNSW uses specialist mental health professionals, such as psychologists, who work with JHMMH nurses and psychiatrists to identify and treat those at risk of deliberate self-harm and/or who are mentally ill.

23. DCJ should consider how the proposed legislative framework for restrictive practices interacts with these existing provisions. Further, DCJ should consider the various professional and ethical obligations of these different healthcare practitioners, noting they are answerable in NSW to the Health Care Complainants Commission.

Forensic mental health settings

24. In NSW, persons who have a disability, whether it be a disability arising from a serious mental illness, or a disability with comorbid serious mental illness, and who are in a mental health facility as a correctional patient, or forensic patient, are all reviewable by the Mental Health Review Tribunal NSW (**MHRT**). The power to administer treatment is provided for in the *Mental Health Act 2007* (NSW) (**MHA**). In addition, ECT (electroconvulsive therapy) requires additional requirements to be satisfied under the MHA. There is an appeal process provided for in the MHA. There are also requirements to notify designated carers (if one is nominated by the person) and Principal Care Providers.

25. There is presently only one declared mental health facility in a NSW prison – that being select beds in the Long Bay Hospital, inside the perimeter fence of the prison. These gazetted beds mean these correctional patients and forensic patients who are placed there are reviewed pursuant to the MHA. Powers to administer treatment is pursuant to the MHA and the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW).

26. However, if the person is placed on a Forensic Community Treatment Order under the MHA whilst in custody (similar to a Community Treatment Order, usually administered by a Community Mental Health Team in the community), then that allows for the provision of mental health treatment in other parts of the prison, but still subject to the MHA.

27. Again, where indicted, in addition to, or independently of, NCAT can make a guardianship order which can include restrictive practices, and/or financial management orders Where restrictive practices are considered by NCAT, the Public Guardian is required to participate at the hearing before an order is made.

28. The Forensic Hospital is a high security hospital and houses forensic patients, high risk civil patients and, in very limited cases, persons who are forensic patients and also subject to a sentence or extended supervision order. Again, persons who are at the Forensic Hospital are reviewed by the MHRT. They often also have guardianship orders in place, which include restrictive practices (although restrictive practices

[7] See, https://correctiveservices.dcj.nsw.gov.au/reducing-re-offending/initiatives-to-support-offenders/specialist-support/at-risk-offenders.html.

are usually not added until the person is closer to discharge and is exercising leave) and they often involve the Public Guardian. So, the mainstay of the power to treat arises under the MHA and the power to detain pursuant to the MHRT under the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW).

29. DCJ should carefully consider how the proposed legislative framework might appropriately operate within the complexity of the forensic mental health setting. In particular, to ensure that persons with disability in the forensic mental health system are not treated unfairly or unequally, or otherwise excluded from the legislative framework. The Association would welcome the opportunity for further consultation on these issues.

Principles governing the use of restrictive practices

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)?

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

30. The Association supports a legislative framework for regulating restrictive practices that is governed by the principles recommended by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. In particular, restrictive practices should only be used in accordance with the following principles:

    (a) 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,

    (b) as the least restrictive response possible to ensure the safety of the person with disability or others,

    (c) to the extent necessary to reduce the risk of harm and proportionate to the potential negative consequences from the use of restrictive practices, and

    (d) for the shortest time possible, consistent with Recommendation 6.35(b) of the DRC Final Report.

31. The Association also suggests that DCJ consider the following additional principles:

    (a) The principles contained in the *Guardianship Act* to ensure consistency between the *Guardianship Act* and any proposed legislative framework to regulate restrictive practices.

    (b) Generally, DCJ should ensure that, where possible, the proposed legislation is not inconsistent with other NSW legislative schemes. This includes the role of formal representatives (attorney and guardian) appointed by either NCAT or the Supreme Court.

    (c) Where possible, terminology should not differ between legislative schemes, as this causes confusion for the participant, carers and family.

Defining 'restrictive practices'

Question 7(i): Do you agree that the framework should use the NDIS definitions of restrictive practices?

32. As outlined in DCJ's consultation paper, section 9 of the *National Disability Insurance Scheme Act 2013* (Cth) defines "restrictive practice" to mean "any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability". This is further clarified under section 6 of the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018. According to the 'NDIS rules', a restrictive practice is a "regulated restrictive practice" if it involves any of: "seclusion"; "chemical restraint"; "mechanical restraint"; "physical restraint"; and/or "environmental restraint".

33. The Association does not offer a settled view as to whether the NDIS definitions of restrictive practices should be used in the proposed legislative framework. However, the Association is concerned that definitions used in NSW – including the NDIS definitions – do not accurately capture restrictive practices and, as a result, there are downstream implications when these definitions are applied in practice.

34. For example, locking medications in a secure cupboard is considered a restrictive practice, as is locking the front door of a community house at night. An NDIS provider must report restrictive practices twice. The first report is to the NDIS Quality & Safeguards Commission and then the second report is to the Office of the Senior Practitioner. Each of those agencies may not agree as to what is a restrictive practice.

35. A practical example would be where a participant has a diagnosis of Huntington's Chorea. This is a debilitating genetic, neurodegenerative disorder that is characterised by involuntary muscle movements, and a progressive loss of speech and deteriorating cognitive function.[8] The participant may require a special bed supplied and approved by the Huntington's Association to keep them safe and to prevent injury as a result of constant movements. This may be considered a restrictive practice, and the pathway for both provider and family members to put safe and appropriate arrangements in place for the participant is unclear. Such a participant may also require a plethora of medicines to manage the many symptoms. It is unclear whether or not some or all of those medicines are also considered a restrictive practice, even when prescribed by consultant physicians as part of a comprehensive medical and allied health plan. This is particularly challenging for providers, who are required to report the medications on a daily basis.

36. Other examples of restrictive practices which may create challenges for people with disability, their family and guardians, NDIS providers, medical specialists and other impacted parties, include:

    (a) If a provider locks the front door of a community house at night to keep everyone safe, even if other doors are open within the building, that is considered a restrictive practice;

    (b) If medications are locked in a cupboard, that is currently a restrictive practice under the Guidelines;

    (c) If a participant has an intellectual disability (such as Prader Willi Syndrome), they may have an insatiable appetite and can overeat. If there is a lock placed on the cupboards or fridge to manage this overeating, it is considered a restrictive practice, even if the condition poses a well-known serious risk to the health and well-being of the participant and the action would be part of an approved multidisciplinary support plan;

    (d) A participant who drinks water out of a toilet bowl cannot have the toilet door locked, because this is a restrictive practice and needs to be approved and reported.

[8] See, for example, Healthdirect.gov.au for a description of 'Huntington's disease': https://www.healthdirect.gov.au/huntingtons-disease

37. As discussed further in response to question 7(ii) below, the Association's view is that people with disability, their families and formal representatives and treating medical specialists should be appropriately consulted when determining what is and what is not a restrictive practice

Question 7(ii): Do you agree that the Senior Practitioner should have the power to issue guidelines that clarify how the definitions apply in different situations?

38. In short, yes. The Association agrees that the "Senior Practitoner", as defined in section 4.2 of DCJ's Consultation Paper, should have the power to issues guidelines that clarify how the definitions apply in different situations. However, the decisions of the Senior Practitioner should consider the views of those with specialist and lived experience of how any potential restrictive practice may operate – including medical specialists who are treating relevant participants and formal representatives of relevant participants. This would help to ensure that impractical outcomes do not occur, such as those discussed throughout this submission. The Senior Practitioner will not have the best day-to-day knowledge of the life of relevant participants, and so targeted consultation should be required before issuing any such guidelines.

Conclusion

39. The Association thanks DCJ for the opportunity to provide feedback to its Consultation Paper. The Association would welcome the opportunity to provide further input in response to any additional consultation processes DCJ may undertake in respect of a potential legislative framework to regulate restrictive practices. Should you have any questions about this submission, in the first instance please contact Sean Robertson, Director, Policy and Law Reform, at [redacted]

Yours sincerely

Dr Ruth Higgins SC
President