THE LAW SOCIETY
OF NEW SOUTH WALES

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3 March 2025

The Policy Manager
Department of Communities and Justice
Locked Bag 5000
Paramatta NSW 2124

By email: policy@dcj.nsw.gov.au

Dear Policy Manager,

LEGISLATIVE FRAMEWORK FOR REGULATING THE USE OF RESTRICTIVE PRACTICES ON PEOPLE WITH DISABILITY

Thank you for the opportunity to provide comments on the Department of Communities and Justice (**DCJ**)'s consultation paper, *A Legislative Framework to Regulate Restrictive Practices* (**Consultation Paper**). The Law Society's Elder Law, Capacity and Succession Committee and Human Rights Committee contributed to this submission.

We are concerned that the proposed legislative framework (**Senior Practitioner framework**) departs from the current consent-based model (outlined at section 3.2.5) in the disability service provision setting, especially in respect of the removal of the requirement to obtain informed consent to the use of a restrictive practice, either from the person or by a substitute decision-maker appointed by the person, or by the NSW Supreme Court or the NSW Civil and Administrative Tribunal (**NCAT**). We suggest that the Senior Practitioner framework and the informed consent framework need not be mutually exclusive but may operate alongside each other. For example, the Senior Practitioner may offer global protections to achieve the principles proposed at section 4.3,[1] while the consent process is retained for individualised decisions about specific restrictive practices used in respect of the person.

As currently proposed, we believe the review, complaints and investigations functions of the Senior Practitioner are insufficient to protect individual rights in the absence of an informed consent mechanism and stronger oversight mechanisms. The proposed processes presuppose the knowledge and capability particular to the affected individual or known to a person with a genuine interest in their welfare, which is necessary to underpin the authorisation of the restrictive practice by the Senior Practitioner. The stringent safeguards and effective oversight mechanisms to guard against the misuse of that restrictive practice by the service provider

[1] The Consultation Paper, at section 4.3 on page 22, proposes for restrictive practices to only be used in accordance with the following principles:
- 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, and
- for the shortest time possible.

THE LAW SOCIETY OF NEW SOUTH WALES
170 Phillip Street, Sydney NSW 2000
ACN 000 000 699 ABN 98 696 304 966
lawsociety.com.au

T +61 2 9926 0333 F +61 2 9231 5809
E lawsociety@lawsociety.com.au

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are also lacking. Even when the persons concerned do avail themselves of the rights to seek review or complain, there is a significant practical time delay between the application for review or complaint and the decision being handed down by the Senior Practitioner or NCAT. The inability to withhold or withdraw consent means the person would still have been subject to the use of the challenged restrictive practice in the intervening period.

If informed consent is retained alongside the proposed Senior Practitioner framework, it benefits the person to have an additional and more personal oversight of the use of the restrictive practice than can be afforded by the more distant and less personalised oversight offered by the Senior Practitioner and/or the Authorised Program Officer (**APO**). It would also provide more timely resolutions to challenges to the authorisation or use of restrictive practices than the inevitable waiting period inherent in internal or administrative review, and complaints and investigation processes.

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?

We note that the Consultation Paper acknowledges the Senior Practitioner framework would not cover the aged care setting. The new *Aged Care Act 2024* (Cth), passed on 25 November 2024 and coming into effect on 1 July 2025, requires, in relation to restrictive practices, informed consent (s 18(1)(f)), and enables rules to be made to make provision for persons or bodies who may give informed consent if an individual lacks capacity to give that consent (s 18(2)). The consultation draft of the new Aged Care Rules 2025 was released recently.[2] Proposed clause 162-15(1)(f) requires:

> *Informed consent to the use of the restrictive practice, and how it is to be used (including its duration, frequency and intended outcome), has been given by:*
>
> *(i) The individual; or*
>
> (ii) *If the individual lacks the capacity to give that consent – the restrictive practices substitute decision-maker for the restrictive practice*

The existing *Quality of Care Principles 2014* (Cth) have the effect of requiring a guardian or an enduring guardian to consent to the use of restrictive practices.

We believe that the proposed framework for the disability service provision setting should be aligned with the consent requirements of the aged care framework in respect of restrictive practices. We understand that proponents of the Senior Practitioner framework contend that an advantage of the framework is that it would obviate the need to obtain consent from the person or their substitute decision maker, thereby cutting 'red tape' and streamlining decision-making convenience in respect of restrictive practices. This appears to be at odds with a person-centric model that prioritises the rights of the individual.

[2] Aged Care Rules 2025 (Cth), Consultation draft, 80: https://www.health.gov.au/sites/default/files/2025-02/new-aged-care-act-rules-consultation-release-3-provider-obligations_0.pdf.

In our view, if decisions about the use of restrictive practices in the disability sector were to be made by a single government official, such as the proposed Senior Practitioner, or their delegate, there is a risk that a "one size fits all" approach will be adopted. This could result in individuals not receiving the due attention necessary to ensure that the proposed restrictive practice is appropriate and tailored for their individual circumstances and in accordance with the principles outlined at section 4.3. We acknowledge that the APOs are intended to mitigate this risk through their knowledge of the operational environment, and we outline our concerns about the APO framework further below. We remain concerned about the risk of the overuse of restrictive practices, which was a subject of criticism by the Royal Commission into Aged Care Quality and Safety.[3]

We are concerned there may be gaps between policy intent and implementation. Even if a restrictive practice is authorised by the Senior Practitioner and/or the APO in accordance with the principles at section 4.3 and best practice, it is likely to be difficult for the Senior Practitioner and/or APO to monitor how each approved restrictive practice is implemented. We are concerned that there is no effective safeguard against a service provider implementing an authorised restrictive practice only to the extent necessary or for the shortest time possible, which are two of the principles outlined at section 4.3. Without informed consent, we query how the person or their substitute decision-maker could understand the decision to implement restrictive practices or be made aware of any misuse of restrictive practices, let alone complain or seek a review of decisions in relation to the use of a restrictive practice.

From a legislative perspective, the Senior Practitioner framework appears to be inconsistent with Part 5 of the *Guardianship Act 1987* (NSW) (**Guardianship Act**), which makes it unlawful for a health practitioner to carry out medical treatment on a "patient" (a person who is incapable of giving consent to the carrying out of medical or dental treatment) without approval of the "person responsible". At common law, a medical practitioner must obtain informed consent before carrying out medical treatment on a person: *Rogers v Whitaker* (1992) 175 CLR 479; [1992] HCA 58. A similar requirement is contained in the code of conduct governing medical practitioners in NSW: *Good medical practice: a code of conduct for doctors in Australia* at [4.5].

Part 5 of the *Guardianship Act* operates to permit a health practitioner to carry out medical and dental treatment on a person who is incapable of giving consent to the carrying out of that treatment where the consent of the "person responsible" is obtained. In the Senior Practitioner framework as it relates to the use of the restrictive practice, "chemical restraint" appears to by-pass the requirement in Part 5 of the *Guardianship Act* that a health practitioner must obtain consent to the use of "medication … for the primary purpose of influencing a person's behaviour",[4] from either the person for whom the medication is proposed, or, if they lack capacity to consent to the proposed medication, the person responsible or the NCAT". We note that the administration of antibiotics in some situations requires consent and it therefore seems inconsistent with the principles at section 4.3 for anti-psychotics to be approved as behaviour support without similar consent.

[3] Royal Commission Final Report: Care, Dignity and Respect Volume 3A, 108: https://www.royalcommission.gov.au/system/files/2021-03/final-report-volume-3a.pdf.
[4] Definition of "chemical restraint" at section 4.5.1, page 23 of the Consultation Paper.

We suggest that DCJ further considers the interaction between Part 5 of the *Guardianship Act* and the Senior Practitioner framework. We believe that informed consent is fundamental and should not be removed or replaced by the Senior Practitioner framework. Rather, consent should operate alongside the Senior Practitioner framework for individualised cases of restrictive practice use.

Question 10: Should APOs be empowered to give authorisation or provide preliminary approval?

The Consultation Paper proposes the use of an APO who is an employee of the provider with training in behaviour support. The Consultation Paper acknowledges that because the APO is employed by the provider, there may be a potential or perceived conflict of interest. However, it is suggested that this could be mitigated by: regulation of the APO; that all APO decisions be notified to the Senior Practitioner; and that all decisions by the APO be reviewable.[5] The Consultation Paper describes a partially delegated model, where the APO can solely authorise some categories of restrictive practices while others must be directly authorised by the Senior Practitioner, or a two-step model where the APO provides preliminary authorisation, which must be formally approved by the Senior Practitioner.[6] In Victoria, environmental and chemical restraints are approved by an APO alone, with the exception of a person with a psycho-social disability, which requires approval by the Senior Practitioner and an APO.[7]

In our view, the use of an APO employed by the provider who approves any restrictive practice appears contrary to the recommendation of the Royal Commission into Aged Care Quality and Safety that the use of restrictive practices in aged care must be based on an assessment by an independent expert.[8] Even with the proposed mitigations, an APO is not an independent expert and there is a direct conflict of interest. In our view, an APO is not an adequate substitute for informed consent to the use of a restrictive practice, either from the person or by a substitute decision-maker appointed by the person, or by the NSW Supreme Court or the NCAT. For these reasons we would oppose empowering an APO to give authorisation or provide preliminary approval.

Question 15: Should authorisation decisions be open to internal review and then reviewable at NCAT?

The Consultation Paper proposes that an affected person, the NDIS provider and any person who has a genuine concern for the welfare of the affected person may seek independent review of the decision to authorise or not authorise a restrictive practice. The review rights would be first to the Senior Practitioner for internal review and then to NCAT.

We assume the internal review process will be covered by the *Administrative Decisions Review Act 1997* (NSW) (**ADR Act**). The review rights available in the ADR Act are insufficient to address the concerns we have raised in this submission for several reasons.

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[5] NSW Department of Communities and Justice, *A legislative framework to regulate restrictive practices*, Consultation Paper (2024) 30.
[6] Ibid 30-31.
[7] Ibid 30.
[8] Royal Commission Final Report: Care, Dignity and Respect Volume 3A, 109: https://www.royalcommission.gov.au/system/files/2021-03/final-report-volume-3a.pdf.

First, a person or their substitute decision maker who wishes to challenge a decision made by the Senior Practitioner in relation to the authorisation of a restrictive practices may lack the ability to avail themselves of the opportunity to seek administrative review under the ADR Act. It is difficult to see how the internal review can be independent when the Senior Practitioner is reviewing their own authorisation decision. We query who the Senior Practitioner reports to, and how independence and transparency may be safeguarded in the proposed structure for internal review.

Second, it is likely that the challenged decision will have been in operation for some months by the time NCAT has completed its review of the challenged decision. Under the ADR Act, the making of an application to NCAT for administrative review of a reviewable decision does not stay or otherwise affect the operation of that decision.[9] Factoring in the time taken to conduct an internal review of the challenged decision,[10] several months may have elapsed between the making of the decision and the handing down of the NCAT decision. In the intervening period, the person may have been subject to the use of the challenged restrictive practice.

We suggest that further consideration is given to the possible risks to the person resulting from the length and possible delays in the internal and administrative review processes. The removal of consent mechanisms means the individual or their substitute decision-maker has lost the right to give, withhold or withdraw consent for the use of the restrictive practice. Without informed consent, we query how the person or their substitute decision-maker could understand the Senior Practitioner's decision to authorise restrictive practices or be made aware of any misuse of restrictive practices, let alone complain or seek a review of decisions in relation to the use of a restrictive practice. Even if they do avail themselves of the rights to review or complain, the proposed process appears to relocate the burden or 'red tape' on the individual to challenge the decision or misuse and defeats the some of the principles at section 4.3, including 'to the extent necessary' and 'for the shortest time possible', for the reasons of time delay outlined above.

The Consultation Paper discusses sanctions and potential civil and criminal remedies, but in a process that lacks oversight, except for the individual oversight by "any person who has a genuine concern for the welfare of the affected person", it may be difficult to access these sanctions and remedies, including in a timely way. We suggest further consideration is given to improve transparency and oversight, and an effective pathway to redress where warranted.

If you have any queries about the items above, or would like further information, please contact Mimi Lee, Policy Lawyer, on [redacted] or [redacted].

Yours sincerely,

Jennifer Ball

Jennifer Ball
President

[9] *Administrative Decisions Review Act 1997* (NSW) s 60.
[10] Ibid s 63.