PEOPLE WITH DISABILITY AUSTRALIA

A voice of our own

Submission to the NSW Department of Communities & Justice Review of a Legislative Framework to Regulate Restrictive Practices

FEBRUARY 2025

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About PWDA

People with Disability Australia (PWDA) is a national disability rights and advocacy organisation made up of, and led by, people with disability. We have a vision of a socially just, accessible and inclusive community in which the contribution, potential and diversity of people with disability are not only recognised and respected but also celebrated.

PWDA is funded to provide cross-disability systemic advocacy on behalf of people with disability in NSW under the NSW Department of Communities and Justice's Disability Advocacy Futures Program (DAFP).

PWDA was established in 1981, during the International Year of Disabled Persons. We are a peak, non-profit, non-government organisation that represents the interests of people with all kinds of disability. We also represent people with disability at the United Nations, particularly in relation to the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

Our work is grounded in a human rights framework that recognises the CRPD and related mechanisms as fundamental tools for advancing the rights of people with disability.

PWDA is a member of Disabled People's Organisations Australia (DPO Australia), along with the First People's Disability Network, National Ethnic Disability Alliance, and Women with Disabilities Australia.

DPOs collectively form a disability rights movement that places people with disability at the centre of decision-making in all aspects of our lives.

The work of PWDA embraces the 'Nothing About Us, Without Us' motto of the international disability community and Disabled Peoples' International, the international organisation representing national organisations of people with disability in over 130 countries.

Endorsement of this submission

This submission has been endorsed by the following organisations:

Children and Young People with Disability Australia

https://cyda.org.au/advocacy/

Down Syndrome Institute

https://www.downsyndromeinstitute.org.au/

Down Syndrome NSW

https://www.downsyndromensw.org.au/

Family Advocacy

https://www.family-advocacy.com/

Muscular Dystrophy NSW

https://mdnsw.org.au/

Submission recommendations

Key overarching recommendations/principles

Principle of Full Elimination

There must be clear indication in the legislation and related materials of how the use of restrictive practices is to be reduced and a pathway to full elimination realised.

Principle of Co-design

People with disability must be included in a genuine co-design process in the drafting and review of all legislation, regulations, rules and policies regarding restrictive practices.

Specific recommendations based on Consultation Paper

Recommendation 1 – Rights, Consent, Support

- The legislative framework for restrictive practices, must include:

  a. A recognition that human rights including those identified in the Convention on the Rights of Person with Disabilities (CRPD) and the Convention on the Rights of the Child (CRC) must guide all decision-making.

  b. A clear pathway to the elimination of restrictive practices.

  c. A statement recognising the importance of consent and that it must form part of any decision-making for the authorisation of restrictive practices in NSW.

  d. A recognition that the government has an obligation to ensure that support, including supported decision-making must be provided for people with disability to assist them in identifying and making their will and preferences clear in all decisions affecting them.

Recommendation 2 – Independence and people with disability in management and advisory roles

- The independent status of the Senior Practitioner must be clarified.
- The office of the Senior Practitioner must include people with disability in key management and advisory positions to ensure that decisions are made with and not for people with disability.

Recommendation 3 – Supported decision-making

- The overarching importance of providing supported decision-making prior to a restrictive practice being authorised (and at other points through the process including assisting in review) must be identified and made explicit in the legislation, and not just left as part of a wider principle. Access to supported decision-making, as a driver of elimination, must be recognised in the legislation as a right as identified in article 12 of the Convention on the Rights of Persons with Disabilities (CRPD).

Recommendation 4 – Scope of legislation (settings)

- A specific restrictive practices legislative framework to regulate restrictive practices in NSW must be developed now to cover all those subject to restrictive practices regardless of setting (this includes health, mental health, education, justice, OOHC, and aged care), regardless of whether they are a NDIS participant, and regardless of existing policies and regulations.

Recommendation 5 – Scope of Senior Practitioner (authorisation)

- If a Senior Practitioner model in the legislative framework is to be adopted then they must authorise or oversee all restrictive practices, not just those used in the provision of NDIS funded services by NDIS providers. This must be included now in legislation, in line with the views of Disability Royal Commission (DRC) Recommendation 6.35(a), and the necessity of this as expressed by the DRC in its Final Report.

Recommendation 6 – Scope of Senior Practitioner (review)

- If a Senior Practitioner model in the legislative framework is to be adopted, then review and reporting processes under their office must be available to all persons affected by restrictive practices, not just NDIS participants.

- The Senior Practitioner must provide all necessary assistance and support, including supported decision-making, to assist an impacted person to seek review of a decision. This right to request support, including supported decision-making, must be made clear in the legislation.

PWDA position on Restrictive Practices

PWDA sees restrictive practices as a form of legalised institutional violence that is applied in a disproportionate and discriminatory way against people with disability.[1]

PWDA is disappointed that the Disability Royal Commission (DRC) did not recommend the elimination of all restrictive practices despite significant research available to them to assist in the development of a pathway to elimination.

While PWDA is supportive in principle of DRC Recommendation 6.36 to immediately end certain forms of restrictive practices and DRC Recommendation 6.35 to impose stricter principles and controls on the authorisation and use of restrictive practices, PWDA believes that the goal should be to eliminate rather than reduce all forms of restrictive practice. Support for DRC Recommendation 6.35 is based on a clear pathway to elimination being developed and progressing.[2]

PWDA is concerned with the significant reported increase in the use of unauthorised restrictive practices.

PWDA believes that a strategy to reduce and eliminate the use of restrictive practices must be based on a holistic understanding of the factors that drive someone's behaviour. In this context PWDA see what are referred to often in literature and policy as 'behaviours of concern' as one legitimate response by a person with disability to a difficult situation. Supports need to be provided to the person with disability to empower them to navigate contexts safely in a way that is protective of their inherent autonomy and dignity.

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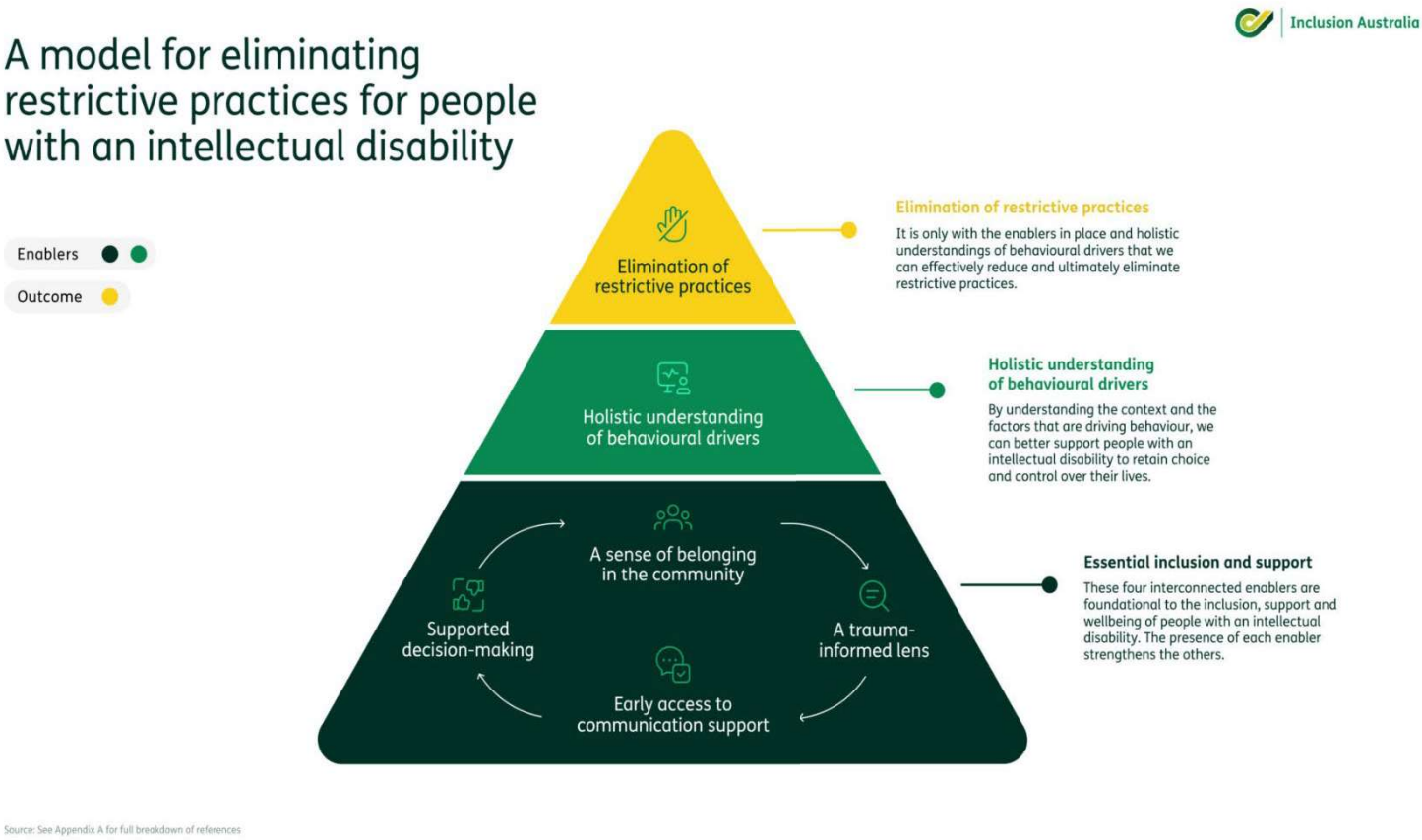
[1] Linda Steele, 'Lawful institutional violence against disabled people' (2017) Issue 143 Nov/Dec 2017 *Precedent* 4. <https://www5.austlii.edu.au/au/journals/PrecedentAULA/2017/67.html>.

[2] PWDA, *Response to the Disability Royal Commission Final Report* (January 2024) Positions 15 and 16 <https://pwd.org.au/wp-content/uploads/2024/02/PWDA-Response-to-the-DRC-Final-Report_Feb-2024.pdf>. See also PWDA, *Authorisation of Restrictive Practices in NSW*. Submission to NSW Restrictive Practices Authorisation in NSW Consultation (August 2019) <https://pwd.org.au/submission-on-restrictive-practices-authorisation-in-nsw/>.

PWDA is supportive of the *Model for eliminating restrictive practices for people with an intellectual disability* developed by Inclusion Australia[3] (see image below). This Model takes a holistic and trauma informed lens to supporting, understanding, reducing and eliminating restrictive practices. PWDA believes this model provides a strong rights-based foundation for further discussion and development.



[3] Inclusion Australia, *A model for eliminating the use of restrictive practices against people with an intellectual disability* (June 2024) available at <https://www.inclusionaustralia.org.au/resource/a-model-for-the-elimination-of-restrictive-practices/>.

Observations of and concerns with the proposed NSW legislative framework

A. Concern that consent based models are being minimised or dismissed out of hand.

PWDA believes that informed consent should always be a requirement for the authorisation of restrictive practices, notwithstanding some concerns raised about consent in practice in some settings by the Disability Royal Commission.

Consent is intimately linked to the protection, promotion and realisation of human rights. It is an expression of autonomy and dignity. Consent is an important safeguarding mechanism.

Consent by the person subject to a decision about restrictive practices should be sought. Where this is not possible, including after the provision of supported decision-making and all other efforts to determine the persons will and preferences, (in line with the Australian Law Reform Commission (ALRC) emphasis on identifying the will, preferences and rights of a person subject to a decision on restrictive practices in its National Supported Decision-Making Principles),[4] then a legally recognised carer, supporter or representative should be required to provide informed consent after participating in and reviewing the proposed decision.

It is clear from the Consultation Paper that there is an overuse of substituted decision making, highlighting that 'substitute consent' was given in 95.7% of cases (Consultation Paper, p.16). PWDA calls for a genuine and disability led effort to significantly reduce the reliance on substitutes, with the aim to transition to supported decision making, through the provision of appropriate supports.

[4] Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (Report 124, August 2014) 251. <https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-alrc-report-124/>.

We are concerned by the Consultation Paper emphasis on saying the "individual rarely consents personally" and that personal consent "is only 4.3%" of restrictive practices authorised (Consultation Paper, p.16). This emphasis on "rarely" and "only" significantly minimises the significance of personal consent for that 4.3% of people. These are people, holders of rights. It implies that the 4.3% are an administrative burden of some kind, and that administrative efficiency trumps the protection and promotion of our human right to participate fully in decisions about us, and to have that respected.

Identifying individual consent only occurs in 4.3% of cases is not an argument against a consent-based model. As noted above, the focus of the agency should be on providing more supports to people with disability so that they can fully participate in their support and behavioural plans and express their will and preferences.[5]

Recommendation 1: The legislative framework for Restrictive Practices, must include:

a. A recognition that human rights including those identified in the Convention on the Rights of Person with Disabilities and the Convention on the Rights of the Child must guide all decision-making.

b. A clear pathway to the elimination of Restrictive Practices.

c. A statement recognising the importance of consent, and that it must form part of any decision-making for the authorisation of restrictive practices in NSW.

d. A recognition that the government has an obligation to ensure that support, including supported decision-making must be provided for people with disability to assist them in identifying and making their will and preferences clear in all decisions affecting them.

[5] See for example, United Nations Committee on the Rights of Persons with Disabilities, *General comment No.1. Article 12: Equal recognition before the law*, CRPD/C/GC/1 (2014) <https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-comment-no-1-article-12-equal-recognition-1>.

B. Lack of clarity around independent status of Senior Practitioner and disability voice in decision-making by them.

If a Senior Practitioner Model is to be adopted, then the Senior Practitioner must be an independent statutory authority as stated by the Disability Royal Commission (DRC) (DRC Final Report Vol 6., p.512).

It is not clear from the Consultation Paper whether the Senior Practitioner will be a wholly independent body. Language describing the Senior Practitioner as a "government official" is vague.

This has implications for how 'independent' any review mechanisms are. DRC Recommendation 6.35(b) notes that

- Decisions to authorise restrictive practices should be subject to **independent** review, and
- The use of restrictive practices should be subject to **independent** oversight and monitoring.

The independence of the Senior Practitioner is critical to creating a degree of trust in its ability to protect and promote the rights of persons with disability subject to restrictive practices.

Additionally, the lack of detail around focus on this body as disability led or managed, is of clear concern, thereby increasing potential for decisions to be made for and not with people with disability.

Recommendation 2:

- The independent status of the Senior Practitioner must be clarified.
- The office of the Senior Practitioner must include people with disability in key management and advisory positions to ensure that decisions are made with and not for people with disability.

C. Supported decision-making prior to restrictive practice being authorised on a person.

Restrictive practices must be a last resort. The DRC states that "supported decision-making should be promoted as a means of reducing and preventing the use of restrictive practices" (DRC Final Report, Vol.6, p.508). People with disability have a right to supported decision-making as identified in article 12 of the Convention on the Rights of Persons with Disabilities. The Consultation Paper is silent on how the provision of supported decision-making will be operationalised.

Recommendation 3: The overarching importance of providing supported decision-making prior to a restrictive practice being authorised (and at other points through the process including assisting in review) must be integrated and made explicit in the legislation, and not just left as part of a wider principle. Access to supported decision-making, as a driver of elimination, must be recognised in the legislation as a right as identified in article 12 of the Convention on the Rights of Persons with Disabilities (CRPD).

D. The Consultation Paper says that principles to apply to the use of restrictive practices (in all settings) "would apply to the provision of NDIS funded services by NDIS providers. The principles would also be applicable to the use of restrictive practices on NDIS participants by government agencies and their contractors in the health, education and justice settings" (Consultation Paper, p.10).

We note that the current Consultation Paper does not actually envisage in practice that the prosed legislative framework and the oversight of the Senior Practitioner will encompass a broad range of settings apart from disability service provision at this time.

It is not clear whether the legislative model proposed, and the Senior Practitioner role applies only to NDIS participants. The Consultation Paper does state that "[a]t this time, DCJ proposes that the disability service provision setting covers the provision of NDIS funded services which NDIS providers provide to NDIS participants" (p.15).

Neither of the above observations are satisfactory considering the broad range of settings in which people with disability engage with.

We cannot keep waiting for amendments down the road (or assume they will be forthcoming) or idly wait for a "definition to evolve" for disability settings and service provision (Consultation Paper, p.15) as the Government is suggesting will happen once the scope of Foundational Supports is developed: "It is proposed that further consideration be given to the definition of the disability service provision setting once the cohort of people who will receive Foundational Supports is clearer" (Consultation Paper, p.16).

Leaving out key definitions and key clarity of the scope of operation of the framework and model will result in weak, ineffective legislation.

Recommendation 4: A specific restrictive practices legislative framework to regulate restrictive practices in NSW must be developed now to cover all those subject to restrictive practices regardless of setting (this includes health, mental health, education, justice, OOHC, and aged care) regardless of whether they are a NDIS participant, and regardless of existing policies and regulations.

E. The Consultation Paper says the legislative framework proposed *would* apply to the disability service provision, health, education and justice settings (p.15) [presumably only for NDIS participants]. The Consultation Paper indicates the Senior Practitioners would only "authorise or oversee authorisation of restrictive practices used in the provision of NDIS funded services by NDIS providers" (p.10) or as otherwise called "disability service provision settings" (p.15).

PWDA submits that Disability Royal Commission (DRC) Recommendation 6.35 as a whole (and in particular the principles outlined in DRC Recommendation 6.35(b)), should apply to all people subject to restrictive practices regardless of whether they are a NDIS participant.

Not all persons with disability or those subject to restrictive practices are NDIS participants. This is especially the case in closed settings for example.

The regulation of the unauthorised use of restrictive practices must also be considered.

While DRC Recommendation 6.35(c) does speak to a Senior Practitioner model being applied to disability service provision the DRC (Final Report Vol 6, p.52) suggests it should in time be extended to other settings (without giving any timeframe). DRC Recommendations 6.35(a) and (b) are not, we would argue, dependent on DRC Recommendation 6.35(c) for their operation.

In other words, a legislative framework to regulate restrictive practices across multiple settings as explicitly envisioned in DRC Recommendation 6.35(a), based on strong principles (DRC Recommendation 6.35(b)), can operate without reference to NDIS status *or* the need for a Senior Practitioner.

Importantly, there is no time limit referred to in DRC Recommendation 6.35(a) as to when a consistent legal framework should be applied to other settings apart from disability settings (and the text alluding to extending to other settings is not part of

the recommendation and is vague). A framework covering other settings can be developed and implemented *at the same time*.

We note by way of example that in the Australian Capital Territory, section 8(1)(a) of the *Senior Practitioner Act 2018* (ACT)[6] means that the Senior Practitioner and the legislation does apply not only to disability service providers, but also all 'education' providers and 'care and protection of children' providers which would include Out of Home Care. While that *Act* does exclude correctional services and mental health services, it still provides for a broader scope of services than that currently proposed in NSW. It also provides the ability to add services and settings through regulations.

Recommendation 5: If a Senior Practitioner model in the legislative framework is to be adopted then they must authorise or oversee all restrictive practices, not just those used in the provision of NDIS funded services by NDIS providers. This must be included *now* in legislation, in line with the views of DRC Recommendation 6.35(a), and the necessity of this as expressed by the DRC in its Final Report.

F. Does independent review of the authorisation process only apply to a NDIS participant? Are supports provided for a person seeking review if requested by them?

It is not clear from Part 5.5 of the Consultation Paper whether the proposed review process of an authorisation decision only applies to a NDIS participant. This is related to the question of whether a Senior Practitioner (the first level of review) is only responsible for NDIS participants.

The Consultation Paper is silent on what supports will be made available to an impacted person seeking review of a decision to authorise restrictive practices. Supports must be provided to an impacted person to allow then to realise their *rights* to review. This would include the provision of *supported decision-making* services by the statutory agency/review body.

[6] *Senior Practitioner Act 2018* (ACT) <https://www.legislation.act.gov.au/a/2018-27>.

Recommendation 6: If a Senior Practitioner model in the legislative framework is to be adopted, then review and reporting processes under their office must be available to all persons affected by restrictive practices, not just NDIS participants.

The Senior Practitioner must provide all necessary assistance and support, including supported decision-making, to assist an impacted person to seek review of a decision. This right to request support, including supported decision-making, must be made clear in the legislation.

G. The Consultation Paper needs to better address how the unauthorised use of restrictive practices will be dealt with under the proposed legislative framework.

There is little clarity in the Consultation Paper as to how the use of unauthorised restrictive practices will be prevented and monitored.

Response to specific questions in the Consultation Paper

Consultation Paper Questions and Proposals

Part 3.4 Other settings in which restrictive practices are used

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

Yes. 51% of children in residential OOHC are NDIS participants. We also know that many children in OOHC with disability are undiagnosed or underdiagnosed meaning that the actual number of children and young people with disability in care is higher than the NDIS participant numbers would show. The ACT *Senior Practitoner Act 2018* does cover OOHC.

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

Yes. PWDA submits that as a minimum, legislation and the principles recommended by DRC Recommendation 6.35(b) should apply across all settings (this includes health, mental health, education, justice, OOHC, and aged care) and to all persons subject to restrictive practices, (including the use of non-authorised restrictive practices), not just those who are NDIS participants. Legislation should be drafted to reflect this now, rather than waiting to potentially amend the legislation in the future or add regualtions.

PWDA is particularly concerned that restrictive practices, such as restraint and seclusion continue to be regularly used in school settings for purposes other than protection from harm. Research shows that restrictive practices are being used in

schools as a means of "coercion, discipline, convenience or retaliation".[7] The alarming extent of this was further highlighted by Children and Young People with Disability Australia (CYDA) in their May 2023 Report *How deep does it go? Australian students with disability and their experience on entrenched inequity in education*.[8]

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?

The principles to underpin a legislative framework out lined in DRC Recommendation 6.35(b) can and should apply to all settings. These principles can be applied on an individual basis to consider individual contexts.

There is the scope for challenges around the type of restrictive practice used and the consistency of application of exiting restrictive practices as people with disability engage with the aged care system particularly after age 65 when they may no longer be a NDIS participant. This has the risk of creating considerable distress and further loss of autonomy for people with disability.

Part 4.3 Principles governing use of restrictive practices

All responses from PWDA to the proposals put forward must be reviewed through the lens of our position as an organisation.

- We believe restrictive practices should be eliminated, as recommended by Spivakovsky, Steele and Wadiwel in their report *Restrictive practices: A pathway to elimination* prepared for the Disability Royal Commission.[9]

[7] Tony S McCarthy, 'Regulating restraint and seclusion in Australian Government Schools. A Comparative Human Rights Analysis' (2018) 18(2) *QUT Law Review* 194, 200. <https://lr.law.qut.edu.au/article/view/746.html>.
[8] Children and Young People with Disability, *How deep does it go? Australian students with disability and their experience of entrenched inequity in education* (May 2023) <https://cyda.org.au/how-deep-does-it-go-australian-students-with-disability-and-their-experience-of-entrenched-inequity-in-education/>.
[9] Claire Spivakovsky, Linda Steele and Dinesh Wadiwel, *Restrictive Practices: A pathway to elimination.* Report prepared for Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (July 2023) <https://disability.royalcommission.gov.au/publications/restrictive-practices-pathway-elimination>.

- Until that time, we need clear reporting on when they are used and accountability when they are misused – including a complaints mechanism that 'has teeth'.
- People with disability have a right to freedom and liberty under the Convention on the Rights of Persons with Disabilities (CRPD), and restrictive practices should not impinge on this, regardless of what a service provider might believe is appropriate.
- The recommendations focus on legal frameworks for restrictive practices, however, we urgently need to examine and address the drivers of this practice
    - For example, restrictive practices may be used due to inappropriate environments, a lack of support, lack of disability understanding or service provider convenience.
- This work should be done at a national level.

Consultation Paper 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).

Support in principle. PWDA submits that as a minimum, legislation and the principles recommended by DRC Recommendation 6.35(b) should apply to all person*s* subject to restrictive practices, not just those who are NDIS participants. Legislation should be drafted to reflect this now, rather than waiting to potentially amend the legislation in the future.

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.

Support in principle. PWDA submits that as a minimum, legislation and the principles recommended by DRC Recommendation 6.35(b) should apply to all persons subject to restrictive practices, not just those who are NDIS participants. Legislation should

be drafted to reflect this now, rather than waiting to potentially amend the legislation in the future.

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 6.35(b)?

Yes. In principle. However, PWDA submits that as a minimum, legislation and the principles recommended by DRC Recommendation 6.35(b) should apply to all persons subject to restrictive practices, not just those who are NDIS participants. Legislation should be drafted to reflect this now, rather than waiting to potentially amend the legislation in the future.

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

The Convention on the Rights of Persons with Disabilities (CRPD) **must** be considered in all legislative and policy actions concerning people with disability so that all actions are consistent with the obligation of Australian governments to protect, promote and realise the rights of people with disability as contained in the CRPD.

Other international human rights instruments must also be considered where relevant particularly when considering the impact of intersectionality. These would include:

- International Covenant on Civil and Political Rights
- International Covenant on Economic, Social and Cultural Rights
- Convention on the Rights of the Child
- Convention on the Elimination of All Forms of Discrimination Against Women
- Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment (and the Optional Protocol)
- United Nations Declaration on the Rights of Indigenous peoples

Further overarching principles must be considered:

Principle of Co-design

People with disability must be included in a genuine co-design process in the drafting and review of all legislation, regulations, rules and policies regarding restrictive practices.

Principle of Full Elimination

There must be clear indication in the legislation and related materials of how the use of restrictive practices is to be reduced and a pathway to full elimination realised.

Part 4.4 Prohibited restrictive practices

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

Yes. Legislation must outline all prohibited practices clearly. All practices identified by the Disability Reform Council in December 2019 as recognised by the Disability Royal Commission in Recommendation 6.36 should be included in legislation. These should be applied across all settings.

PWDA further supports Disability Royal Commission Recommendation 6.36 to prohibit certain restrictive practices in addition to the ones identified by the Disability Reform Council. This includes prohibiting the use of seclusion on children and young people with disability in disability service settings and prohibiting a range of other practices in health and mental health settings. These should be incorporated into legislation.

Part 4.5 Defining restrictive practices

Question 7: Do you agree that:

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

No.

PWDA recognises that there is a need for consistency in definitions of restrictive practices used amongst agencies and jurisdictions as noted in the Consultation Paper (p.24). However, we do not feel that the NDIS definition of restrictive practices in section 9 of the *National Disability Insurance Scheme Act 2013* (Cth) (*NDIS Act*) goes far enough to highlight the significant trauma associated with the use of restrictive practices or identify the broad type and complexity of restrictive practices in use.

PWDA believes the definition developed by Spivakovsky, Steele and Wadiwel [10] (extracted below) provides a more precise definition that recognises people with disability are holders of fundamental rights and that restrictive practices impinge those rights by stripping people with disability of dignity, and should be considered by the legislative review team:

> **Restrictive practices are legally authorised and/or socially and professionally sanctioned violence that targets people with disability on a discriminatory basis and are at odds with the human rights of people with disability.** Restrictive practices include, but are not limited to, chemical, mechanical, physical and environmental restraint and seclusion, guardianship, forced sterilisation, menstrual suppression and anti-libidinal medication, financial management, involuntary mental health treatment, and other non-consensual or coercive interventions said to be undertaken for protective, behavioural or medical reasons.[11]

Spivakovsky, Steele and Wadiwel[12] provide reasons why their definition is to be preferred. PWDA is in broad agreement with these. These reasons they provide are:

1. First, restrictive practices represent a form of violence people with disability experience that is legally and/or socially and professionally sanctioned. This means that this violence not only has formal authorisation by law and policy,

[10] Claire Spivakovsky, Linda Steele and Dinesh Wadiwel, *Restrictive Practices: A pathway to elimination*. Report prepared for Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (July 2023) <https://disability.royalcommission.gov.au/publications/restrictive-practices-pathway-elimination>.
[11] Ibid 1-2, 17-18.
[12] Ibid 18.

but it is also embedded as a practice in formal and informal settings with a significant degree of social and professional endorsement.

2. Second, we note that our understanding of 'violence' extends to 'coercive and non-consensual' interventions, as described … by the United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Whether use of restrictive practices can be legitimated if its recipient has previously consented – but does not consent at the time of application – is contentious and will be discussed further … . However, the above definition assumes that a restrictive practice is by definition a 'coercive and non-consensual' measure; that is, a form of violence.

3. Third, the definition we provide emphasises that the term 'restrictive practices' refers to a range of practices used against people with disability on a discriminatory basis.

Similarly, specifically in terms of the **types** of restrictive practices identified in section 6 of the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (NDIS Rules) PWDA does not feel that the five categories identified – Seclusion, chemical restraint, mechanical restraint, physical restraint and environmental restraint adequately captures the complexity of restrictive practices.

PWDA does not feel that the 'types' or 'categories' of restrictive practice should be rigidly closed, though they all may contain an element of coercion or non-consensual intervention.

Some of these additional 'types' have been identified above by Spivakovsky, Steele and Wadiwel in their definition:

> [G]uardianship, forced sterilisation, menstrual suppression and anti-libidinal medication, financial management, involuntary mental health treatment, and other non-consensual or coercive interventions said to be undertaken for protective, behavioural or medical reasons.[13]

In a 2017 Report for the ACT Government on minimising and eliminating restrictive practices, JFA Purple Orange also identified the following types of restrictions and

[13] Ibid 1-2, 17-18.

restraints which PWDA is in broad agreement with and which are not included in the NDIS Rules:

- **social**, such as the imposition of sanctions that restrict the person's access to relationships/opportunities they value
- **psycho-social restraints**, such as power control strategies which might include threats, intimidation, fear, coercion, discipline, or retaliation
- **organisational**, such as excluding the person from activities, and restrictions to the person's choice
- **communication restraint**, such as switching off someone's communication device
- **decision making restraint**, such as failing to provide options for supported decision making.[14]

PWDA notes that article 12 of the CRPD states that a person with disability has a right to receive **supported decision making** and that States parties must provide this. Refusing decision-making support is not just a breach of human rights, **it can also amount to a restrictive practice**.

Finally, PWDA considers that an **omission** or otherwise *not* acting or preventing something from occurring, or taking away from someone a thing which could reasonably be foreseen to have the effect of restricting the rights or freedom of movement of a **person with disability,** may fall under the definition of a restrictive practice in section 9 of the *NDIS Act* as "any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability."

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

[14] JFA Purple Orange, *Minimising and Eliminating Restrictive Practices. A Consultation for the ACT Government*. Final Report (June 2017) <https://purpleorange.org.au/~purpleor/application/files/2715/5735/4860/Minimising_and_Eliminating_Restrictive_Practices._consultation_report_prepared_by_JFA_Purple_Orange_for_ACT_government_final.pdf>.

PWDA believes that any guidelines around the identification and application of restrictive practices in settings must be made through a **co-design process** with people with disability.

Part 5.2 Restrictive practices must be part of behaviour support plans

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

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

Yes. A BSP must consider intersectional and all identity matters and how the BSP supports those. This could include matters such as LGBTQIA+ identification, and cultural considerations, such as First Nations heritage. Cultural considerations for example must include the development of an appropriate **cultural safety plan** to accompany the BSP.

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

Yes. There should be a nationally recognised tertiary level qualification at a postgraduate level (at least Graduate Certificate or Graduate Diploma depending on undergraduate degree, and likely as a Masters 'qualifying' degree program depending on undergraduate degree) within a health sciences school, or a specific sequence of subjects a student could undertake at an undergraduate level as part of an appropriate undergraduate degree. The graduate program could be structured similar to existing professional graduate qualifying courses for Psychologists or

Social Workers or Teachers and similar which permit entry to a recognised professional body.

The program should have a structured work experience element and further structured work supervision post-graduation.

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

PWDA believes that consent of the person subject to a restrictive practice should always be the goal. In all instances PWDA believes that the person subject to the restrictive practice *must* be part of the consultative process around the BSP and their views given appropriate weight.

The central goal of the consultative process must be to protect the rights of the person subject to the BSP and reduce or eliminate the use of restrictive practices. The person subject to the BSP must have resources and information made available to them so they are able to participate in and understand the process. This should include the provision of independent **supported decision-making**, and the opportunity to express their will and preferences to independent parties.

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

No response provided.

Part 5.3 Authorisation models

Question 10: Should APOs be empowered to either:

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

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

No response provided.

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

No response provided.

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?

No response provided.

Part 5.4 Duration of authorisation

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

Yes, in principle.

It must be made clear that in the case of the emergency use of a restrictive practice this is still governed by the key principles on the use of restrictive practices identified in DRC Recommendation 6.35(b). In other words, it must be only used as a last resort for example. It is critical that people working with people with disability where restrictive practices are or may be used are properly trained in the application of the principles to minimise harm, and to recognise the significant role behaviour often has in being a form of communication, rather than as a behaviour of 'concern'.

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

No response provided.

Part 5.5 Independent review rights

Question 15: Should authorisation decisions:

- **be open to internal review?**
- **be reviewable at NCAT**?

Yes. All restrictive practices authorisation decisions should be open to internal review and be reviewable by NCAT.

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 appropriate person for a service provider to speak to about a BSP and restrictive practices of a client is:

- The client
- The clients' family/carers/supporters/representatives
- The person who created the BSP

It needs to be clarified whether a service provider is unable to implement the BSP for some reason, or if it is not working in practice. This would be part of a regular standard review process between the client, the person who created the BSP and the service provider. Part of this process would be to review the operation of restrictive practices including examining whether they need to be reduced (not just authorised).

It would be concerning that a service provider could seek to usurp existing checks and balances and cause some clients to be labelled as "too hard" rather than the service provider deploying the necessary resources to ensure it can provide safe services within an existing BSP that has been through approval processes. The service needs to fit around the client, rather than having a client fit around a service.

There is a risk that some clients may miss out on services if they are labelled “too hard”.

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

No response provided.

Part 5.6 Complaints handling and investigations

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

If a Senior Practitoner Model is adopted, they should have both complains handling and investigation functions.

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

Yes.

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

No response provided.

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?

The Senior Practitioner should have the power to share information to law enforcement agencies where there is a high likelihood of harm having occurred or reasonably likely to occur because of conduct by a provider, individual or agency that would constitute a criminal offence. This would include maters including neglect, physical and psychological harm, fraud, and child abuse matters.

The Senior Practitioner should have the power to share information with relevant agencies to ensure compliance with the legislation and rules where it is reasonably suspected a breach has occurred.

The Senior Practitioner may have need to communicate and liaise with other agencies that a person with disability is also engaging with to ensure they are receiving the appropriate supports and services for example. This may also include working with specific First Nations and other cultural organisations to ensure that BSP's reflect cultural needs.

Generally, as a matter of principle, the person subject to the BSP must be consulted with prior to information being shared. Informed consent must be received from them and if not able to be provided by them including after the providing of supported decision-making then informed consent from a recognised carer, supporter or representative of the person with disability that recognises the rights of the person with disability.

Part 5.7 Reporting

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?

No response provided.

Part 5.8 Education and guidance functions

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

Yes. PWDA submits that a key function of the Senior Practitioner should be to reduce and eliminate the use of restrictive practice. Education and guidance are part of this process towards full elimination.

Part 5.9.1 Sanctions (Liability)

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?

The Senior Practitioners should have sufficient power and 'teeth' to ensure that Behaviour Support Practitioners, service providers and others are at all times acting within a strict legal and professional ethical framework, and in a manner consistent with upholding the human rights of the person with disability. This could include the ability of the Senior Practitioners to bring civil actions and actions before a professional disciplinary tribunal against a Behaviour Support Practitioner for example.

Given the serious and complex nature of punitive, coercive and other disciplinary powers potentially able to be wielded by the Senior Practitioner, and how these may intersect with other existing disciplinary process (including civil and criminal processes), this should form part of a separate Consultation process.

Part 5.9.2 Immunity from liability (Liability)

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?

No response provided.

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

No response provided.

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