26th February 2025

The following document aims to provide a detailed response to the Consultation Paper: *A Legislative Framework to Regulate Restrictive Practices (December 2024).* The responses have been prepared by Interaction Services’ Behaviour and Allied Health Services (BAHS) team members, thus aims to respond from the perspective of Behaviour Support Practitioners responsible for the identification of NDIS Quality and Safeguards Commission (QSC) Regulated Restrictive Practices (hereafter restrictive practices). This document will aim to address changes to the proposed DCJ models within the disability setting.

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

Yes, currently there are significant differences between NDIS QSC policies and DCJ policies. This is considered to create significant inconsistency for participants who reside in the out of home care settings while also be engaged with NDIS services. It is recommended that DCJ legislation is consistent across all New South Wales (NSW) government services.

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

Yes, as per the response to question 1 inconsistency between the legislation of NSW government services can create challenges for the provision of policies and procedures across settings and services. It is proposed that, where possible legislative frameworks are aligned.

*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?*

Multiple issues and challenges have been identified through the review of the consultation paper, as well as ongoing provision of NDIS behaviour support services within the aged care settings. The different frameworks for the authorisation of restrictive practices frequently impacts on the ability for the behaviour support practitioner and the aged care stakeholder team to assess, identify and implement restrictive practices. This is due to different understanding of what constitutes a restrictive practice; for example, the aged care setting identifies a chemical restraint as a psychotropic medication prescribed for either the diagnosis of a condition or to treat behaviours of concern, whilst the QSC identifies a chemical restraint as a medication aimed to modify the participant’s behaviours of concern where the medication has not been prescribed for the treatment of a diagnosed medical condition.

As per the example above, it is common for difficulties in the authorisation of restrictive practices to arise thus creating significant barriers to the monitoring and safeguarding of participants subject to restrictive practices while residing in the aged care setting. Further, the knowledge and training levels of those supporting participants subject to restrictive practices differs vastly between disability settings and the aged care settings; it is of concern that such differences may lead to negative outcomes for participants who are supported between the disability and aged care service settings.

Furthermore, participants are funded in accordance with reasonable and necessary need for their behaviour supports. This is usually for participants within NDIS settings or within the family home. Increased funding is used to assess, identify and implement restrictive practices in other settings under different legislation frameworks, which is not always considered and funded in the participant’s NDIS plan. Therefore, more funding is used when there are differences in legislative frameworks.

***Proposal 1:*** *Legislation should provide that the use of restrictive practices on NDIS participants in the disability service provision, health, education and justice settings should be governed by the principles recommended by DRC Recommendation 6.35(b).*

***Proposal 2:*** *The legislation should require government agencies in the health, education and justice settings to provide an annual report to the Senior Practitioner on their, and their contractors’, compliance with the principles.*

*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, the principles outlined in this recommendation are important safeguards for participants and are reflective of the principles proposed by the NDIS QSC.

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

Yes, to ensure the appropriate use of restrictive practices it is recommended that the use of restrictive practices is subject to independent oversight as per the current NSW DCJ authorisation model. Should changes to the current model occur, it is further recommended that an alternate method of independent monitoring is introduced. The ongoing need for monitoring of the use of restrictive practices and advocacy support for participants and their stakeholders when concerns with the implementation of restrictive practices arise should also be provided; it is noted that the current NSW authorisation pathways does not include opportunity for appeal and this is something that requires additional consultation and change.

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

No current changes to the prohibited practices outlined in the *DCJ Prohibited Practice Policy 2019* are recommended.

***Proposal 3:*** *The NDIS definitions of restrictive practices should be adopted for the NSW legislative framework for restrictive practices.*

***Proposal 4:*** *The Senior Practitioner should have the power to issue guidelines that clarify how the definitions apply in different situations.*

*Question 7- Do you agree that:*

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

Yes, as noted in the response to question 2 inconsistency of the definition of a restrictive practice across all settings (including NDIS and other NSW government settings) creates barriers to the authorisation of restrictive practices and the safeguarding of individuals subject to restrictive practices. A current concern raised by behaviour support practitioners within NSW is the inconsistency between DCJ definitions of a restrictive practices and the definitions and legal requirements of NDIS QSC restrictive practices. Such inconsistency impacts greatly on the participant and increases the likelihood of incorrectly identifying practices (e.g. medications not considered a chemical restraint by the NDIS QSC, however later identified as a chemical restraint during DCJ Restrictive Practice Authorisation Panels), thus reducing the monitoring and safeguarding of participants as well as the expenditure of unnecessary use of funding.

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

Yes, at the time of current response there is ongoing discussion within the behaviour support community about poor clarity of how the definitions apply across all settings and situations. This is due to different perspectives provided by DCJ Independent Specialists and the absence of clear definitions referred to during the process of authorising NDIS QSC restrictive practices. It is recommended that the Senior Practitioner has the power to issue guidelines and provide clarification from a set of predetermined guidelines and processes; such guidelines and processes must be developed by DCJ and accessible for all providers involved in the authorisation and implementation of restrictive practices. Further, all Senior Practitioners must consistently follow the same guidelines and processes to ensure consistency across all settings.

*Question 8- What role should the Senior Practitioner play in regulating behaviour support plans?*

* *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, the Senior Practitioner should have power to seek further information. It is however noted that, within the current NSW authorisation process, the Independent Specialist will often provide recommendations and conditions for additional and/or more detailed information in the Behaviour Support Plan (BSP). Currently, there is significant inconsistencies between recommendations and conditions provided to the behaviour support practitioner and implementing providers; such recommendations and conditions are considered to be influenced by the Independent Specialist’s professional background. It is important that further development of the models proposed through the consultation paper consider the development of processes to ensure clarity and consistency around prescribing additional and/or more detailed information in the BSP.

* *Should the Senior Practitioner have the power 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? If so, what should the additional qualifications and conditions for approval be?*

No, the Senior Practitioner should not have the power to determine whether a behaviour support practitioner is appropriately qualified to develop a BSP used to support authorisation of restrictive practices. Behaviour support practitioners working within the disability service provisions are currently subject to the rules and frameworks outlined the NDIS QSC. A key rule outlined in the *NDIS (Restrictive Practice and Behaviour Support) Rules* notes that a behaviour support practitioner must be registered through the Positive Behaviour Support Capability Framework (PBSCF) prior to providing NDIS funded behaviour support services. Further, the PBSCF identified the practitioner level and outlines the appropriate monitoring of less experienced behaviour support practitioners; an example of such is the ongoing requirements of clinical supervision for all behaviour support practitioners, as well as direct supervision of core level practitioners throughout all areas of behaviour support though specifically during the identification and implementation of restrictive practices.

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

The NDIS rules provide detailed provisions relating to consultation in the development of a BSP, with the most recent QSC Behaviour Support Plan templates requiring that consultation with the participant and their stakeholders is clearly outlined. The only recommended provision relating to consultation in the development of a BSP highlights inconsistency in providers requesting the attendance of the participant and/or their guardian to Restrictive Practice Authorisation Panels; it is recommended that written notification of the Restrictive Practice Authorisation Panels and written invitation for the participant and/or their stakeholder to attend is provided by the NDIS implementing provider.

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

NDIS behaviour support practitioners are provided detailed and ongoing training and support in the development of a BSP prepared on behalf of the NDIS QSC. There are significant training gaps and limited understanding of DCJs expectations of what should be included within a BSP. It is recommended that DCJ develops and delivers ongoing training in what is expected to be included in a BSP. It is further recommended that the expectations of DCJ and QSC align to ensure that a BSP can be written in a clear and succinct manner that can be easily understood by those responsible for the frontline mediation of the BSP.

***Proposal 5:*** *A Senior Practitioner model should be structured to use APOs as part of the authorisation process. An APO should:*

* *have operational knowledge of how the BSP and proposed restrictive practice would be implemented,*
* *be required to meet prescribed professional standards set by the Senior Practitioner, and,*
* *be approved by the Senior Practitioner.*

*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?*

No, APOs should not have the power to authorise particular models of restrictive practices without senior authorisation. The Partially Delegated Model raises concern due to the limited safeguarding of participants subject to restrictive practices. As proposed, APOs do not have specific training or qualifications in the authorisation of restrictive practices. Further, APOs may demonstrate bias in their authorisation of restrictive practices due to their loyalty to the organisation in which they are employed (either as an employee or as a contractor for authorisation purpose). The Partially Delegated Model removes independent and objective oversight into the authorisation of restrictive practice, as is evidenced within the current model for the authorisation of restrictive practices outlined within an Interim Behaviour Support Plan.

* *Provide preliminary approved of restrictive practices, with final authorisation provided in all cases by the Senior Practitioner (a two-step model)?*

Based on the information provided within the consultation model, a two-step model provides significantly more safeguarding than the APO model for participants subject to restrictive practices due to the independent oversight provided by the Senior Practitioner. The two-step model is the preferred model proposed within the consultation paper, however a short timeframe for final authorisation by the Senior Practitioner must be proposed prior to the implementation of the model.

*Question 11- Are there alternative approaches to authorisation that would be preferable to those models?*

The current model for authorisation of restrictive practices implemented through Comprehensive Behaviour Support Plans is effective in providing safeguarding and independent oversight at the time of authorisation. The current model of authorisation of Interim Behaviour Support Plans clearly highlights the risks associated with an absence of independent oversight; it is considered that the APO model especially would pose the similar risks regarding authorisation of restrictive practices as the current authorisation model for Interim Behaviour Support Plans as follows:

* The implementing provider would be responsible to determining whether a restrictive practice requires authorisation. This would leave scope for unscrupulous implementing providers to authorise unnecessary and/or unethical restrictive practices without oversight from an independent body at the time of authorisation. It may also propose difficulties where restrictive practices outlined in an Interim Behaviour Support Plan as necessary to reduce the risk of harm posed by a participant’s behaviour of concern are not authorised accordingly.
* The quality of a Behaviour Support Plan is not subject to review by an independent person. Thus, poor quality Behaviour Support Plans may be developed and implemented without clearly identifying responses and strategies to reduce the need for restrictive practices.
* The person responsible for the authorisation of the restrictive practices (within the provider) is either a direct employee or engaged as a contractor on behalf of the organisation. Thus, their role and management may reduce their unbiased judgement regarding the need for restrictive practice authorisation.

*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?*

APOs should not be requested to be employed by a single provider. It is considered that allowing APOs to be consultants to a number of providers would increase participant safeguarding. Where an APO consults on behalf of several providers the following benefits are hypothesised:

* Increased and varied training and support due to education in the core values of multiple companies.
* Reduced impact of employer influence (as per final point in question 11) on decision to authorise restrictive practices.

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

***Proposal 7:*** *There should be an emergency use process for restrictive practices before a BSP has been prepared and authorisation given, which should replace the interim authorisation process.*

***Proposal 8:*** *The Senior Practitioner should have the power to cancel an authorisation of restrictive practices where:*

* *the Senior Practitioner has determined there is no longer a need for the restrictive practice,*
* *the Senior Practitioner requests evidence to demonstrate the restrictive practice is still needed and the provider fails to provide sufficient evidence,*
* *the authorisation was obtained by materially incorrect or misleading information or by mistake,*
* *the relevant provider has contravened a condition of the authorisation, or*
* *the relevant service provider has contravened a provision of the legislation*

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

Partially, authorisation of restrictive practices identified within a Comprehensive Behaviour Support Plan based on functional behaviour assessment should remain 12 months in duration; changes to authorisation length (e.g. need for ongoing review, or fade out of practices) may prompt a shorter duration as per the current authorisation model.

Emergency use of restrictive practices will be required regardless of the model implemented. The current model whereby the behaviour support practitioner has one month from identification of restrictive practices to develop an Interim Behaviour Support Plan which is valid for a period of six months. The current model is effective in safeguarding the participants in the context of restrictive practices, as well as providing non-restrictive preventative and responsive strategies. The key concern with only providing six months for emergency use of restrictive practices exists for participants without access to ‘Relationships’ funding. Ongoing delays to requests for change of circumstance review of NDIS Plans coupled with the maximum term of six months emergency restrictive practice use may place participants who are unable to have an immediate NDIS plan review at risk of harm; risk of harm exists where the participant is unable to secure the appropriate funding through an NDIS plan review to allow for the development of a Behaviour Support Plan within the six month period. The current consultation paper does not identify whether the emergency use period for restrictive practices will be extended where there are delays in an updated NDIS plan being provided.

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

Yes, the Senior Practitioner should be able to cancel an authorisation on the following grounds:

* Whereby the restrictive practice has been authorised by the APO through the APO model and the practice does not meet the threshold of least restrictive response required in proportion to the risk of harm posed by the behaviour of concern.
* Whereby the implementing provider does not implement the restrictive practice in accordance with the procedure identified by the Behaviour Support Plan.
* When a review of the restrictive practice partway through the authorisation period indicates that the restrictive practice is no longer required to respond to the risk of harm.

***Proposal 9:*** *An affected person, the NDIS provider and any other person who has a genuine concern for the welfare of the person may seek review of an authorisation decision. The review rights would be:*

* *first to the Senior Practitioner for internal review,*
* *then to the NSW Civil and Administrative Tribunal*

*Question 15- Should authorisation decisions:*

* *Be subject to internal review?*

Yes, a review should initially be completed when concern regarding the authorisation is raised by the participant, their guardian and/or other stakeholders and advocates. This is crucial in ensuring that the restrictive practice is implemented in consultation with the participant and their stakeholders, as well as ensuring that the participant and/or their stakeholders have an initial avenue for response to their concerns.

* *Be reviewable by NCAT?*

There should be a mechanism in place for further review whereby the internal review was not successful in responding to the concerns of the participant and/or their stakeholders. However, it is unclear if NCAT is best placed to fulfil this role, and further consideration of who should be responsible is required prior to the development of legislation.

*Question 16- Should rights to seek review be limited to the person or a person concerned for their welfare? Should the service provider have the right to seek review of a decision not to authorise a restrictive practice?*

The participant, their NCAT appointed guardian, and the service provider should have the right to seek the review of a decision not to authorise a restrictive practice where there is evidence provided that significant risk of harm is posed to the participant or others within their environment as a result of not authorising the restrictive practice.

*Question 17- Should the person have the right to request that the service provider reviews the BSP at any time?*

Yes, a request may be submitted, but its undertaking would depend on the availability of funding and basis of reasonable and necessary. It would be unreasonable to require the practitioner to conduct a review without adequate funding.

***Proposal 10:*** *The Senior Practitioner should have powers to investigate the misuse of restrictive practices, on receipt of a complaint and on its own motion*.

***Proposal 11:*** *The Senior Practitioner should have the following powers to respond to the misuse of a restrictive practice:*

* *direct the provider to do / cease doing something in relation to behaviour support or the use of the restrictive practice,*
* *cancel an authorisation,*
* *refer the matter to the NDIS Commission, police or another relevant entity.*

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

Yes, the Senior Practitioner should have complaints handling and investigation functions when a complaint is made by the participant and/or their stakeholders. Based on the current DCJ authorisation processes the consistency of the manner in which the complaints and investigations are responded to is of concern; as noted previously, there is significant inconsistency between feedback and authorisation requirements between Independent Specialists. It is recommended that a clear procedure for the handling and investigation of complaints is developed and followed by all Senior Practitioners to ensure that all complaints are responded to consistently.

Within the APO model it is considered necessary for the Senior Practitioner to review authorisation provided by the APO. It is recommended that where the Senior Practitioner does not agree with the APO’s decision to authorise the practice an investigation and review of the authorisation should be completed by the Senior Practitioner. This will increase safeguarding of participants subject to the implementation of restrictive practices by allowing additional independent oversight into the authorisation of practices. Where the Senior Practitioner determines that an investigation and review into the authorised restrictive practices is necessary the participant and their stakeholders should be informed in writing and, where appropriate, the participant and/or their stakeholders should be supported to engage with an advocate to provide ongoing support throughout the investigation process.

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

Yes, the Senior Practitioner should have the proposed powers to respond to the misuse of restrictive practices as outlined in the consultation paper. It is however noted that the Senior Practitioner should be required to provide evidence supporting any decision to request that the provider ceases use of the practice and/or to support the cancellation of restrictive practice authorisation. Further, prior to providing the Senior Practitioner the proposed powers in response to the misuse of restrictive practice a legislative framework must be developed and followed consistently by the Senior Practitioner. Finally, it is necessary for all directions regarding the response of the Senior Practitioner to the misuse of a restrictive practice are provided in writing to the disability provider, behaviour support practitioner, participant and/or their guardian; it is recommended that the Senior Practitioner also meets with the involved stakeholders (where possible) to discuss the decision to remove authorisation as well as to review alternate strategies to reduce any identified risks of harm for the participant posed by removal of authorisation.

Further, the Senior Practitioner should refer any criminal misuse of restrictive practices to the police as proposed within the consultation paper. Referral of criminal misuse of restrictive practices should also continue to be reported by any stakeholder providing support to the participant (e.g. behaviour support practitioner, disability service provider).

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

Currently there is inconsistency between the NDIS complaints framework (including the NDIS QSC framework) and the DCJ complaints framework. The NDIS framework follows federal legislation, whilst the DCJ follows state legislation which does not reflect the *NDIS (Restrictive Practice and Behaviour Support) Rules 2018.* The inconsistency between federal and state authorisation processes as well as restrictive practice definitions would make the interaction between the DCJ and NDIS complaints framework difficult; it is firmly recommended as discussed previously that the DCJ and NDIS frameworks are reviewed to provide consistent definitions.

The following recommendation is made:

* The NDIS QSC is responsible for reviewing all restrictive practice complaints that are implemented within a NDIS setting; this includes complaints related to the implementing provider, APO (whereby the APO model is implemented) or the behaviour support practitioner responsible for the development of the Behaviour Support Plan.
* The DCJ Senior Practitioner is responsible for the investigation of all complaints or concerns related to the use of a restrictive practice within a non-NDIS funded setting; this would include restrictive practices identified to be used in the family home (such as those implemented by the participant’s family that pose risk to the participant in the informal setting), aged-care, hospital, education and justice settings.
* Whereby the complaint is made in relation to a restrictive practice utilised in a NDIS setting as well as an informal setting, an initial review is completed between a member of the QSC Behaviour Support Team and the Senior Practitioner. The key risks and concerns related to the misuse of the restrictive practice is discussed with regard to both government agencies policies and procedures. The initial review must also identify how each governing body will investigate and respond to the complaint.

*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 the following bodies:

* The NDIS QSC identifies the framework for restrictive practices within a NDIS setting. The Senior Practitioner should have the power to share information with the NDIS QSC in relation to the authorisation of restrictive practices.
* Further, the Senior Practitioner should have the permission to share information to the NDIS QSC whereby it is determined that a NDIS provider has engaged in poor conduct during the implementation and/or authorisation of a restrictive practice.
* The Senior Practitioner should have the power to share information to the police whereby there are concerns of criminal conduct of a NDIS provider or informal support during the implementation of a restrictive practice.
* The Senior Practitioner should have permission to share information with the health setting whereby the participant requires the use of a restrictive practice during admission or other engagement with the health service; the power to share with health should only be enacted when the participant does not have the supports necessary (e.g. NDIS support staff, NCAT appointed guardian, behaviour support practitioner) to communicate and provide evidence of the required practice at the initial stage of engagement.
* Whereby the Senior Practitioner identifies that a restrictive practice has been used in a manner that poses risk of harm to a child and/or young person under 18 years they must complete mandatory reporting in accordance with legislation to the Child Protection department of DCJ.

*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 NDIS Commission be minimised?*

The reporting burden will remain high due to the inconsistent legislation, policies and procedures between the federal and state bodies. For reporting burden to be reduced it is recommended that a national framework for the authorisation of restrictive practices is developed. This paper has failed to outline the manner in which information related to the use of the restrictive practices will be communicated to the Senior Practitioner, thus is not possible to determine whether appropriate visibility to the Senior Practitioner is provided. Further, this paper fails to note which information the Senior Practitioner will seek when providing authorisation for restrictive practices. It can be assumed that ongoing written evidence related to behaviours of concern and the use of restrictive practices will be required, however the method for this information to be provided should be clarified. The current paper also fails to note whether Restrictive Practice Authorisation Panels will continue and whether the Senior Practitioner will liaise with behaviour support practitioners at the time of authorisation in relation to recommended practices; the potential of reduced interaction with the behaviour support practitioner regarding authorisation and other strategies outlined in the Behaviour Support Plan will greatly reduce the quality of Behaviour Support Plans as well as independent oversight being reflected within the Behaviour Support Plan.

***Proposal 12****: The Senior Practitioner should have the following functions:*

* *developing and providing information, education and advice on restrictive practices to people with disability, their families and supporters, and the broader community,*
* *developing guidelines and standards, and providing expert advice, on restrictive practices and behaviour support planning.*

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

No, the Senior Practitioner should not have the proposed education and guidance functions within the disability setting provision. Currently restrictive practices are identified and implemented by NDIS providers who are required to meet the *NDIS (Restrictive Practice and Behaviour Support) Rules 2018.* Subsequently all education and guidance should be provided by professionals who are registered by the NDIS QSC to ensure that the participant and their stakeholders do not receive inconsistent information. It is proposed that training and guidance continues to be completed by a QSC registered behaviour support practitioner to ensure that training and guidance is relevant and consistent.

*Question 24- Should the Senior Practitioner have the power to impose sanctions of 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?*

As noted above, the NDIS QSC should be responsible for imposing sanctions for the misuse of restrictive practices in any NDIS settings. The QSC should also be responsible for imposing sanctions on a behaviour support provider that does not adhere to the *NDIS (Restrictive Practice and Behaviour Support) Rules 2018.* The Senior Practitioner should be responsible for the imposition of sanctions for the misuse of restrictive practice in non-NDIS settings. Both the QSC and Senior Practitioner should be responsible for reporting any criminal conduct to the New South Wales Police, or harm of a child and/or young adult under 18 years to Child Protection agencies.

Theoretically, the current sanctions for the misuse of restrictive practices are considered sufficient on review of the legislation. It is however emphasised that due to delayed investigation of complaints or failure to investigate complaints means providers may not receive appropriate sanctions.

*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?*

Yes, to an extent. Legislated immunity should be conditional on compliance with (and reporting against) clearly outlined authorisation protocols (as discussed earlier), adherence to identified best practices (including human rights principles), and genuine use of good faith principles. However, even with legislated immunity, there should still be avenues for individuals or stakeholders to raise concerns where restrictive practices may have been improperly applied.

*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?*

Not in addition to what has been discussed previously.