Restrictive practices legislative framework

MENTAL HEALTH COORDINATING COUNCIL

Submission to the Department of Communities and Justice

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mhcc.org.au

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CONTENTS

Submission to the Department of Communities and Justice: Restrictive practices legislative framework

Introduction

Mental Health Coordinating Council (MHCC) is the peak body for community-managed mental health organisations (CMOs) in New South Wales (NSW) and is a Registered Training Organisation (RTO) delivering accredited and non-accredited programs. We represent community-based, not-for-profit/non-government organisations who support people living with mental health challenges. MHCC's 150 members assist people to live well in the community by delivering mental health and psychosocial supports including social inclusion, rehabilitation, and clinical services. Our purpose is to promote a strong and sustainable community-managed mental health sector with the investment, resources, and workforce it needs to provide effective psychosocial, health and wellbeing programs and services to the people of NSW.

MHCC provides policy leadership, promotes legislative reform and systemic change, and develops resources to assist community-based organisations build their capacity to deliver quality services informed by a human rights-based, trauma-informed, recovery-oriented practice approach. MHCC works closely with Mental Health Australia on matters of national interest to the sector, including cross-governmental collaboration, bilateral agreements, and the NDIS, and with the Mental Health Alliance, a partnership of state-based peak bodies and professional associations, on matters of mutual interest in NSW.

In advocating for a human rights-based, trauma-informed and recovery-oriented approach to practice, it is imperative that when discussing the issue of restrictive practices that the primary goal remains the elimination of these practices to all people with disability and the provision of alternative practice approaches to ensure their safety and wellbeing. While MHCC welcome stronger safeguarding and monitoring of the use of restrictive practices across human services settings, there must be greater focus on deterring the use of these practices and greater promotion of positive behaviour supports.

Examples of best practice in this context can be accessed through the NDIS Quality and Safeguards Commission. Their behaviour support team is responsible for providing clinical leadership in behaviour support and promoting the reduction and elimination of restrictive practices. They provide a number of resources to assist workers and regularly facilitate learning webinars[1]. The NDIS Practice Standards also provide guidance in this context. MHCC was also responsible for developing a NDIS Practice Standards Guidebook[2] which is particularly relevant to psychosocial service providers. CMO Open Minds also provide some resources in relation to positive behaviour supports for people living with mental health challenges[3].

In its concluding observations in the last review of Australia's compliance with the Convention on Rights of Persons with Disabilities the report stated that there have been no moves towards: "recommendations that call for the elimination of restrictive practices, nor outline a path to ending them".

The UN Committee urged the State party to: *"establish a nationally consistent legislative and administrative framework for the protection of all persons with disabilities, including children, from the use of psychotropic medications, physical restraints and seclusion under the guise of "behaviour modification" and the elimination of restrictive practices, against persons with disabilities, including children, in any setting, including in justice, education, health, psychosocial and aged care facilities"*, including corporal punishment, in all settings, and the home.

Whilst the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability Report (DRC) includes recommendations about better data collection and reporting, this has not proved to be a deterrent for NDIS providers, who continue to report huge amounts of restrictive practices to the NDIS Commission. In October to December 2022, there were 410,657 incidents, and 439,322 in the following quarter [4].

MHCC support Disability Advocacy Network Australia's reflection from its analysis of the DRC recommendations: *"The management of the regulations continue to rely on people with disability and their families, supporters and advocates making complaints and in the case of the NDIS, the Quality and Safeguards Commission regulating behaviour management plans"*. This list of restrictive practices that the DRC agrees in recommendation 6.36 should be prohibited makes for sobering reading. Without a clear direction and movement towards elimination, this legal violence against people with disability will continue." [5]

We strongly urge policy makers to consider that if accepting the implementation of the legislative framework, in whatever final form it takes, that best practice must foster and work towards elimination. Elimination should be considered as an overarching principle and aspirational objective of the legislation underpinning the framework as a whole. What we want is a model that upholds rights for people with disability, rationalises processes for providers reporting to multiple regulators and keeps regulatory burden to a minimum.

MHCC thank the Government for the opportunity to provide commentary on this significant area of reform and are hopeful that the actions resulting will address the deficits reflected in the UN's Committee on the Rights of Persons with Disabilities concluding observations on the combined second and third periodic reports of Australia. We express our willingness to be consulted on any matters related to this submission.

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Consultation Questions:

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

MHCC agrees that the proposed legislative framework should cover the out-of-home care (OOHC) setting for children and young people, including those with disabilities. This group represents a vulnerable population with diverse needs that are not often fully understood or addressed within the current system[6]. The lack of comprehensive data on the prevalence of disability among young people in OOHC hinders the ability to fully identify and respond to their needs. For example, while data is available for 71% of children in OOHC, it shows that 29% are living with a disability[7], and there is no national data on the prevalence of disability among First Nations children in OOHC, despite their over-representation in the system[8].

Children with disabilities in OOHC face an elevated risk of maltreatment, with research highlighting that they are more vulnerable to neglect and abuse within care settings[9]. A report from the NSW Ombudsman indicated that, in 2021, about 30% of children in residential OOHC experienced some form of restrictive practice at least once during their time in care. The most commonly reported restrictive practices include physical restraint and isolation [10]. Furthermore, many foster carers report a lack of adequate training and support to properly care for children with disabilities, which can lead to unmet needs and suboptimal care[11]. This situation is further compounded for children with disabilities who belong to other priority groups, such as First Nations children, who often face additional barriers to care. For instance, First Nations children with disabilities in OOHC are less likely to have their health and mental health needs met compared to their non-Indigenous counterparts, which exacerbates their vulnerability[12].

A legislative framework that addresses these disparities and ensures a holistic, child-centred approach is crucial. By incorporating trauma-informed practices, the framework can promote better outcomes for children with disabilities in OOHC, particularly by empowering children and young people to participate in decisions regarding their care. It can also encourage collaboration among carers, practitioners, and other professionals to provide tailored, culturally appropriate, and responsive care plans. Ensuring that carers receive the necessary training and support to meet the needs of children with disabilities is also vital for creating a more inclusive and safer OOHC system[13].

The existing Behaviour Support OOH Guidance[14] currently available must be reviewed in the context of a positive behaviour supports approach, and the most contemporary trauma-informed best practice models. Positive behaviour supports must be highlighted in the proposed legislative framework for out-of-home care which is critical for several reasons:

Protection of Vulnerable Individuals: Out-of-home care often involves children and young people who may be particularly vulnerable. A legislative framework can help ensure their rights are protected and that any use of restrictive practices is carefully monitored and justified.

Consistency and Standardisation: By including out-of-home care, the framework can provide consistent standards across all care settings. This helps ensure that all individuals receive the same level of protection and care, regardless of where they are placed.

Accountability and Oversight: A legislative framework can establish clear guidelines and accountability measures for the use of restrictive practices. This can help prevent misuse and ensure that any restrictive practices are used only when absolutely necessary and in the least restrictive manner possible.

Improved Outcomes: Regulating restrictive practices can lead to better outcomes for individuals in out-of-home care by promoting more positive and supportive approaches to behaviour management.

Alignment with Best Practices: Including out-of-home care in the framework aligns with best practices and international standards for the treatment and care of vulnerable individuals.

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

MHCC agree that additional settings should be covered including those suggested in the consultation paper:

> **Educational Institutions:** Schools and other educational settings may include children and young people who exhibit challenging behaviours. Including these settings can help ensure that restrictive practices are used appropriately and only absolutely when necessary.
>
> **Healthcare Facilities**: Hospitals, inpatient mental health facilities, and other healthcare settings sometimes use restrictive practices. A legislative framework can support the regulation of these practices to ensure they are used ethically, safely and ensure accountability.
>
> **Disability Services**: The framework already focuses on people with disabilities and can be expanded to cover a diversity of disability services, including community-based services and residential care.
>
> **Justice and Juvenile Settings**: People in adult justice and correctional settings, and particularly young people in juvenile justice settings may be particularly vulnerable and at risk of restrictive practices. Including these settings can help ensure that any use of restrictive practices is closely monitored and justified.

MHCC are keen to see aged care facilities and services in the community included.

> **Aged Care Facilities and Services in the Community**: Residents in aged care facilities and in the community may also be subject to restrictive practices. Including these settings can help protect their rights and ensure their safety and dignity and highlight the need for accountability.

By covering a wide range of settings, the framework can provide comprehensive protection and ensure that restrictive practices are used only when absolutely necessary and in the least restrictive manner possible, and that justification for these practices must be clearly demonstrated.

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 existence of different frameworks for the authorisation of restrictive practices in disability service provision and aged care settings raises significant concerns in relation to consistency, fairness, and the quality of care for individuals impacted by these practices. One key issue is the prevalence of people with disability under 65 living in residential aged care settings.

Despite ongoing efforts to reduce and eventually eliminate the placement of younger people in aged care facilities, as of 30 June 2024, 1,271 people under 65 continue to live in permanent residential aged care in Australia. Additionally, a small number of individuals continue to enter the aged care system each year[15].

For National Disability Insurance Scheme (NDIS) participants, an alignment between the frameworks governing restrictive practices in both the disability services and aged care sectors is critical. If NDIS participants reside in aged care facilities, they may be subject to different sets of regulations. This can create confusion and inconsistencies in how their rights are protected and how restrictive practices are authorised and managed. For example: the *Aged Care Act 1997* governs restrictive practices in aged care, while the *National Disability Insurance Scheme Act 2013* and associated state/territory legislation regulate practices in disability services. These different frameworks lead to a lack of uniformity in the implementation of restrictive practices, potentially leaving some individuals with disability in aged care without adequate safeguards and oversight that may be available in other settings. Furthermore, creating alignment between these frameworks will support the transition for people moving between different care settings, ensuring that their support needs are met in the least restrictive manner possible.

Having different frameworks for the authorisation of restrictive practices in disability service provision, and in aged care in the community as well as in residential settings can raise several issues and challenges including:

> **Inconsistency in Standards**: Different frameworks can lead to varying standards and practices, which may result in inconsistent care and protection for individuals across settings. This can create confusion for service providers and caregivers who work in multiple settings.
>
> **Complexity and Confusion**: Multiple frameworks can complicate the regulatory landscape, making it difficult for providers to understand and comply with the different requirements. This can lead to unintentional non-compliance and increased administrative burdens.
>
> **Inequity in Protection**: Individuals in different settings may receive different levels of protection and oversight, potentially leading to inequities.
>
> **Training and Education Challenges**: Different frameworks may require different training and education for staff, which can be resource-intensive and challenging to implement effectively.
>
> **Fragmentation of Services**: Separate frameworks can lead to a fragmented approach to care, where best practices and learnings are not shared across settings. This can hinder the development of a cohesive and integrated approach to managing restrictive practices.

Legal and Ethical Dilemmas: Different frameworks may have varying legal and ethical standards, which can create dilemmas for practitioners who must navigate these differences while ensuring the best care for individuals.

Addressing these challenges requires a coordinated approach that seeks to harmonise standards and practices across different settings, ensuring that all individuals receive consistent and equitable protection and care.

DCJ 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).

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)?

MHCC supports legislation that requires restrictive practices on NDIS participants across disability service provision, health, education, and justice settings to be governed by the principles recommended by DRC Recommendation 6.35(b)[16]. These principles align with the core values of dignity, respect, and the right to live free from unnecessary and harmful interventions.

MHCC agrees that restrictive practices should only ever be used as a measure of last resort, and solely in response to a serious risk of harm to the individual with disability or others. Prior to the use of any restrictive practices, all other alternative strategies should be fully explored and implemented to mitigate the risk, ensuring that restrictive measures are truly the most appropriate and necessary response. This aligns with the fundamental principle that the safety and wellbeing of the person should always be prioritised, and that restrictive practices should never be used as a default or routine measure. Providers must continue to strive for the elimination of restrictive practices in their delivery of supports.

Additionally, MHCC agrees that restrictive practices should be legislated to ensure that they are only used in the least restrictive way possible. This ensures that the intervention is proportionate to the risk and that the potential harm caused by such practices is carefully weighed against the necessity of their use. By keeping the use of restrictive practices to the absolute minimum, we can help ensure that individuals with disability retain as much autonomy and freedom as possible, while also safeguarding their safety and wellbeing.

MHCC support that restrictive practices on NDIS participants in disability service provision, health, education, and justice settings should be governed by the principles recommended by DRC Recommendation 6.35(b) for the following reasons:

Consistency and Clarity: Applying a unified set of principles across various settings ensures that there is a consistent approach to the use of restrictive practices. This can help reduce confusion and ensure that all stakeholders understand their responsibilities and the standards they must meet.

Protection of Rights: The principles recommended by the DRC emphasise the protection of individuals' rights and the need for restrictive practices to be used only as a last resort. This aligns with best practices and international standards for the treatment of people with disabilities.

Accountability and Oversight: Establishing clear legal frameworks for the authorisation, review, and oversight of restrictive practices can help ensure that these practices are used appropriately and ethically. This can prevent misuse and promote transparency and accountability.

Holistic Approach: Governing restrictive practices across multiple settings (disability services, health, education, and justice) ensures a holistic approach to care and support. This can lead to better outcomes for individuals by promoting positive and supportive environments.

Alignment with Best Practices: The principles recommended by the DRC are based on extensive research and consultation. Implementing these principles can help align practices with the latest evidence and best practices in the field.

Adopting these principles can support the creation of a more inclusive and just society that supports the independence and rights of people with disabilities.
Refer also to response to Question 2

DCJ 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.

MHCC agrees that decisions to authorise restrictive practices must be subject to independent review. This would ensure that all decisions are made in a transparent and accountable manner, and that there are checks in place to prevent the unnecessary or inappropriate use of restrictive measures. Independent oversight and monitoring are essential to maintain confidence in the system, to protect the rights of people with disability, and to ensure that restrictive practices are only used appropriately and in line with best practice standards.

Requiring agencies to provide an annual report to the Senior Practitioner on their compliance with the principles could be highly beneficial because it would lead to enhanced accountability; improved monitoring and oversight; and more effective regulation. It will also promote data-driven improvements which will help identify trends, challenges, and best practices. This information can be used to inform policy decisions and improve the overall approach to managing restrictive practices. Compliance with principles will also foster greater consistency across settings and create a more cohesive and integrated system for managing restrictive practices. All the above are likely to improve public confidence and build public trust and confidence in the systems that are in place to protect vulnerable individuals. In addition to these benefits annual reporting could be a valuable tool for ensuring that restrictive practices are used appropriately and ethically across different settings.

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

Legislation should mandate a human-rights based, person-led and trauma-informed approach in the development of Behaviour Support Plans (BSP) and in decisions regarding the authorisation and monitoring of restrictive practices. People with disability should be actively involved in decisions that affect their care, and where possible assisted by workers that are able to provide supported decision-making, ensuring their voices are heard and their preferences are respected. People must be supported to give voice to their preferences where they experience difficulties in doing so.

Given the high prevalence of traumatic experiences among people with disability, it is critical to recognise and respond to trauma in care settings. This includes the experience of carers, kin and allies who may be witness to the use of restrictive practices and therefore creating generational trauma from the use of restrictive practices. Any use of restrictive practices must be carefully considered to avoid the risk of re-traumatisation. This approach ensures that care is tailored to the individual's lived experience, aspirations and needs, as well as their history of trauma, fostering a sense of safety and empowerment.

The various impacts of restrictive practices on a person's human rights should be explicitly highlighted in the legislation. Restrictive practices can significantly affect an individual's autonomy and dignity, so it is essential to frame their use within the broader human rights context. The legislation should promote the elimination of restrictive practices where possible, encouraging a shift towards alternative, more supportive approaches to care. This principle underscores the importance of respecting the rights and freedoms of individuals with disability, while also ensuring that any interventions are truly necessary and proportionate.

In environments where multiple people with disabilities reside, it is important to ensure that the use of restrictive practices for one individual does not negatively impact the rights and freedoms of others. In settings such as group homes or residential care facilities, the actions taken to manage one person's behaviour should not create an environment of restriction, trauma or fear for other residents. The principle of maintaining a safe and supportive environment for all individuals should be embedded in the legislation, ensuring that any restrictive measures are applied with sensitivity to the collective rights and well-being of the entire group.

To enhance the framework for restrictive practices they should also be time-limited and continuously reviewed and monitored to ensure they are used no longer than needed [17]. Wherever possible informed consent should be obtained from the individual or their legal representative before implementing restrictive practices. All instances of restrictive practices should be thoroughly documented, including the reasons for their use, the duration, and the outcomes. This promotes transparency and accountability. Principles must include ensuring that staff are trained and skilled in the appropriate use of restrictive practices, including alternative strategies and de-escalation techniques. This ensures that they are equipped to handle challenging situations without resorting to restrictive practices unnecessarily.

Of critical importance is the need for an individualised approach in which each person's needs and circumstances are considered when deciding on the use of restrictive practices. No one-size-fits-all approach is appropriate. Likewise, mechanisms must be implemented that include the regular review and oversight of restrictive practices to ensure compliance with the established principles and to identify areas for improvement[18]. Incorporating these principles can help create a more ethical, effective, and person-centred and person-led approach to the use of restrictive practices.

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

A legislative framework should prohibit certain practices to ensure the safety, dignity, and rights of individuals with disability are upheld across all settings. A critical practice that should be explicitly prohibited is the misuse of medication, particularly when medication is administered contrary to prescriber instructions for the purpose of influencing or altering an individual's behaviour.

The legislation should consider additional prohibited practices specifically for young people with disability. This vulnerable group is particularly at risk of being subjected to harmful interventions that may negatively impact their development and well-being and have traumatic consequences. Practices such as solitary confinement, or any form of punishment-based restrictive practices, should be prohibited for young people in all settings.

Any restrictive practice that has not been formally authorised by a proper process or legal framework should be prohibited and reportable and should never be used as a tool for power and control. The use of practices such as seclusion, restraint, or denial of access to essential services or activities as a form of behaviour management, punishment, or manipulation of the individual should be prohibited.

The legislative framework should also include the prohibition of devices that cause harm when used as mechanical restraint. This includes devices such as handcuffs, leg restraints, ropes used to tie hands or other body parts, and any other devices identified by the NDIS Commission[19] as being harmful when used on people with disability. These devices should be prohibited in all settings, including residential care, hospitals, and other environments where people with disability reside or receive services. Any practice that is degrading, inhumane, or violates the dignity of the individual should be prohibited in all settings. By prohibiting these practices, the legislative framework can help ensure that restrictive practices are used only when absolutely necessary and in the least restrictive manner possible, protecting the rights and well-being of individuals across all settings.

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

Question 7a. Do you agree that: the framework should use the NDIS definitions of restrictive practices?

Aligning the legislative framework with the NDIS definitions of restrictive practices is an important step towards promoting national consistency across the disability sector. Consistent definitions help service providers, carers, and practitioners to clearly understand what constitutes a restrictive practice and how it should be applied or managed in a variety of contexts. This consistency reduces confusion, improves accountability, and ensures that all people with disability, regardless of where they live or which service they access, are afforded the same protections. If changes are made to the NDIS definitions, it is essential that these changes are reflected in the NSW legislative framework to maintain alignment and ensure that the definitions are consistently applied across both state and national systems.

‘Power and control’ should be explicitly defined as a standalone restrictive practice. This type of behaviour, where individuals use their power to intimidate, manipulate, or control the actions and behaviours of a person with disability, is harmful and undermines the autonomy and dignity of the individual. Explicitly including this in the framework as a restrictive practice ensures that it is acknowledged, prevented, and addressed. By defining ‘power and control’ as a restrictive practice, workers are also better equipped to identify and intervene in situations where it may be happening, offering further protection for people with disability.

Using the NDIS definitions of restrictive practices in the framework can be beneficial for several additional reasons including:

Comprehensive Coverage: Since NDIS definitions cover a wide range of restrictive practices, including physical, chemical, mechanical, environmental, and seclusion, comprehensive coverage ensures that all forms of restrictive practices are addressed.

Ease of Implementation: Many service providers are familiar with the NDIS definitions, and adopting these definitions in the framework would simplify implementation and compliance.

Overall, using the NDIS definitions would support a more effective and unified approach to managing restrictive practices, ensuring the rights and safety of individuals are protected.

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

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

The Senior Practitioner should have the power to issue guidelines that clarify how the NDIS definitions apply in different situations and provide consistency. Clear and specific guidelines are essential for ensuring that restrictive practices are used appropriately and only when absolutely necessary. However, these guidelines should be co-designed with meaningful input of people with disability, service providers, and other key stakeholders. This ensures that the guidelines reflect the lived experiences and needs of individuals with disability, and that service providers have the tools and guidance they need to implement the framework effectively. Co-designing these guidelines also fosters a more inclusive and collaborative approach, ultimately leading to better outcomes.

Different situations may require different approaches and guidelines can offer tailored advice on how to handle specific scenarios, ensuring that restrictive practices are used appropriately and ethically. Clear guidelines can support practitioners by providing practical examples and best practices. This can help them make informed decisions and reduce the risk of misuse.

Importantly guidelines can establish clear expectations and standards, making it easier to monitor and review the use of restrictive practices, and improving accountability and oversight. The Senior Practitioner can also update guidelines to reflect the latest research and best practices, ensuring that the framework remains current and effective. In summary, empowering the Senior Practitioner to issue guidelines can help create a more effective and responsive framework for managing restrictive practices.

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

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

The Senior Practitioner should have the power to prescribe additional and more detailed information for inclusion in the BSP. This information should be co-designed with people with disabilities, service providers, and key stakeholders. Suggested areas for review and information could include:

- A dedicated section for cultural information/needs, rather than including this in 'social history'.
- A dedicated section for gender to ensure gender-affirming and inclusive practice.
- Clear evidence that, where possible, people were consulted on all aspects of their plan, with their voice and comments included throughout.
- Detailed (risk assessment) information on potential risks associated with the individual's behaviour and the use of restrictive practices. This can help in planning and implementing safer and more effective interventions.
- Personalised strategies for managing behaviours based on the individual's unique needs, preferences, and circumstances.
- Clear guidelines on how the use of restrictive practices will be monitored and reviewed, including the frequency of reviews and the criteria for evaluating the effectiveness of the interventions.
- Documentation of how the individual and their family or legal representatives have been involved in the development of the BSP, including their consent and any feedback they have provided.
- Information on the training and support that staff will receive to implement the BSP effectively and safely. This can include details on specific training programs and ongoing support mechanisms.
- A list of alternative less restrictive strategies that have been considered and/or tried before resorting to restrictive practices. This demonstrates a commitment to using the least restrictive options.
- Information on any cultural, linguistic, or contextual factors that need to be taken into account when implementing the BSP. This ensures that the plan is respectful and appropriate for the individual.
- Detailed plans for managing crises or emergencies, including specific actions to be taken and who is responsible for each action. This helps ensure a coordinated and effective response.

By including this additional information, BSPs can be more comprehensive and effective, ultimately leading to better outcomes for individuals.

B. 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 which will be used to authorise the use of a restrictive practice? If so, what should the additional qualifications and criteria for approval be?

The Senior Practitioner should have the power to require behaviour support practitioners to have certain qualifications and obtain the Senior Practitioner's approval before preparing a BSP that authorises the use of restrictive practices. While a single set qualification may not be beneficial due to the varied backgrounds of practitioners (e.g., psychology, social work, occupational therapy, mental health and disability support), it is essential to ensure that workers possess extensive relevant experience, they receive thorough onboarding training, they have strong experience in the disability sector, as well as a deep understanding of restrictive practices and hold the motivation to eliminate and reduce their use in practice.

A minimum number of years of professional experience in behaviour support or a related field is likely to ensure that practitioners have practical experience in addition to their academic qualifications and relevant certification and accreditation that supports knowledge of established standards of practice.

Practitioners should also be required to engage in ongoing professional development to stay current with the latest research, techniques, and ethical standards in behaviour support and supported decision-making. Practitioners should be able to demonstrate that they adhere to a code of ethics that emphasises the rights and dignity of individuals, the use of the least restrictive practices, and the importance of informed consent.

Practitioners should be subject to approval by the Senior Practitioner, who can assess their qualifications, training, and experience. This approval process can include an evaluation of their competency in developing and implementing BSPs. By implementing these qualifications and criteria, the framework can help ensure that BSPs are developed by competent and ethical professionals, ultimately leading to better outcomes for individuals.

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

There should be specific provisions relating to consultation in the development of a BSP. These provisions should ensure that:

- The process is inclusive and participatory, involving people with disabilities, their families, and other key stakeholders.
- The voices and preferences of the individuals for whom the BSP is being developed are clearly documented and reflected in the plan.
- Continuous feedback mechanisms are in place to adapt and improve the BSP based on ongoing consultation and input.
- Consultation should involve a multidisciplinary team to ensure a holistic and comprehensive approach to behaviour support.
- The consultation process should consider the cultural and linguistic background of the individual and their family and ensure that the BSP is culturally appropriate and respectful.
- There should be provisions for regular review and feedback from all stakeholders involved in the consultation process to ensure that the BSP remains relevant and effective over time.
- Clear and open communication should be maintained throughout the consultation process with information shared with all stakeholders about the purpose, goals, and content of the BSP.
- The consultation process and the input received from various stakeholders should be thoroughly documented providing accountability supported by a clear record of how the BSP was developed.

By incorporating these additional provisions, the consultation process for developing BSPs can be more inclusive, comprehensive, and effective, ultimately leading to better outcomes for individuals.

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

The framework must ensure that BSPs are evidence-based, trauma-informed, recovery-oriented, include supported decision making and reflect a human rights approach. This approach acknowledges the impact of past trauma on people and emphasises their right to dignity, respect, and autonomy. By integrating these principles, BSPs can better support the holistic wellbeing and empowerment of people with disabilities and ensure that strategies and interventions used are effective and up-to-date [20].

The quality of BSPs is safeguarded through comprehensive assessments that provide in-depth information about the individual's needs, strengths, and their known environmental factors. This supports the creation of a more tailored and effective plan[21].This is additionally assisted through the implementation of mechanisms for regular monitoring and evaluation of the BSP's effectiveness. This can help identify areas for improvement and ensure that the plan is achieving its intended outcomes. Importantly the BSPs should include detailed crisis intervention plans to address potential emergencies and ensure a coordinated response.

By incorporating these measures, the framework can help ensure that BSPs are of high quality, effective, and supportive of the individual's needs and rights.

DCJ 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?**
- **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?

Each option for delegating roles and responsibilities presents distinct risks and benefits.

Partially Delegated Model: If certain restrictive practices are to be authorised by Authorised Program Officers (APOs) without separate Senior Practitioner authorisation, it is essential that these practices be clearly defined and regulated. The provision of 'class or kind' orders, rather than rigid legislation, could offer the flexibility needed to address the unique and varying needs of each provider. This approach allows for a more tailored response to individual circumstances while maintaining oversight.

The benefits of this model are that it:
- can streamline the authorisation process, reducing delays and allowing for quicker implementation of necessary restrictive practices.
- empowers APOs to make decisions based on their direct knowledge and understanding of the individual's needs and circumstances.
- can reduce the workload on the Senior Practitioner, allowing them to focus on more complex cases.

However, there are some potential risks which are:

- There may be inconsistencies in how restrictive practices are authorised across different settings and APOs.
- Reduced oversight could lead to potential misuse or overuse of restrictive practices.
- Ensuring that all APOs have the necessary training and competency to make these decisions can be challenging.

Two-Step Model: The two-step model, where APOs provide preliminary approval and the Senior Practitioner gives final authorisation, could add an administrative layer but offers significant benefits in safeguarding the rights and safety of people with disabilities. This model ensures a higher level of scrutiny and accountability, which is crucial in working towards the elimination of restrictive practices.

Some benefits of this model are that it:

- ensures that there is an additional layer of oversight, reducing the risk of misuse.
- promotes consistency in the authorisation of restrictive practices across different settings.
- distributes the responsibility between APOs and the Senior Practitioner, ensuring that decisions are well-considered.

Some potential risks are that:

- the two-step process may lead to delays in the implementation of necessary restrictive practices.
- it can increase the workload for both APOs and the Senior Practitioner, potentially leading to bottlenecks.
- the process may become more complex and cumbersome, requiring clear guidelines and communication.

Both models have their merits and challenges. The choice between them depends on the specific needs and context of the settings in which they are implemented.

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

There is an alternative approach to authorisation that could be considered:

> **Decentralised Authorisation with Enhanced Training:** In this model, authorisation is decentralised, but all practitioners involved in authorising restrictive practices receive enhanced training and certification. This is efficient because of faster decision-making at the local level. The model empowers local practitioners with the knowledge and skills to make informed decisions and allows for more tailored responses to individual needs. However, it has the potential for inconsistency with variations in standards and practices. Also, ensuring all practitioners maintain high standards can be challenging to quality control aspects.

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?

One possible option is for APOs to be employed by the same department as the Senior Practitioner. This approach would ensure aligned expertise and maintain independence from the providers. Additionally, it would help avoid placing financial strain on providers who may not be able to afford to employ a full-time or part-time APO.

Allowing APOs to be consultants to multiple providers can offer flexibility and access to a broader range of expertise. However, there are important safeguards that should be in place to ensure the integrity and effectiveness of this approach which include:

Access to Expertise: Smaller providers may benefit from the expertise of experienced APOs who may not be available for full-time employment.
Flexibility: APOs can offer their services to multiple providers, ensuring that their skills and knowledge are utilised effectively.
Cost-Effective: Consulting arrangements can be more cost-effective for providers who may not need a full-time APO.

However, there are safeguards to consider:
Conflict of Interest Policies: Clear policies should be in place to manage and mitigate any potential conflicts of interest. APOs should disclose any relationships with multiple providers and ensure that their decisions are impartial.
Standardised Training and Certification: APOs should undergo standardised training and certification to ensure they meet consistent standards across all providers they work with.
Regular Audits and Reviews: Regular audits and reviews by an independent body, such as the Senior Practitioner, can help ensure that APOs are complying with regulations and maintaining high standards.
Clear Documentation and Reporting: APOs should maintain clear and detailed documentation of their decisions and actions. This transparency can help ensure accountability and facilitate oversight.
Limits on Caseload: There should be limits on the number of providers or cases an APO can manage to ensure they can provide adequate attention and support to each one.
Supervision and Support: APOs should have access to supervision and support from senior professionals to help them navigate complex cases and maintain high standards of practice.

By implementing these safeguards, the framework can ensure that allowing APOs to be consultants to multiple providers does not compromise the quality of care or the integrity of the authorisation process.

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

DCJ 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.

DCJ 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?

MHCC support the proposed duration of authorisation and emergency use proposals for restrictive practices, with the following considerations:

> **Consistency across frameworks:** It is crucial to maintain consistency between NDIS restrictive practice legislation and the DCJ framework. This alignment ensures clarity and uniformity in the application of restrictive practices, benefiting both providers and individuals with disabilities.
>
> **Emergency use framework:** MHCC agree with the proposed emergency use of restrictive practices framework based on section 145 of the *Disability Act 2006* (VIC). This framework provides a structured and legally sound approach to managing emergencies before a BSP is in place.
>
> **Reporting requirements:** To enhance accountability and oversight, it is recommended that the APO provide the Senior Practitioner with a report on each emergency use of restrictive practices as soon as practicable, rather than relying on monthly reports. This timely reporting ensures that any issues are promptly addressed and that the use of restrictive practices is closely monitored.
>
> **Time-Limited Authorisation**: Restrictive practices should be authorised for a specific, limited duration, typically not exceeding 12 months. This ensures regular review and reassessment of the necessity and appropriateness of the practices.
>
> **Regular Reviews:** There should be mandatory reviews at regular intervals (e.g., every 3-6 months) to assess the ongoing need for restrictive practices and to explore less restrictive alternatives.

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

There are several additional grounds on which the Senior Practitioner should be able to cancel an authorisation for restrictive practices. These grounds can help ensure that restrictive practices are used appropriately and ethically. Some examples evident in the Qld Legislation include:

> **Evidence of Harm:** If there is evidence that the use of restrictive practices is causing harm to the individual, the Senior Practitioner should be able to cancel the authorisation immediately1.

Lack of Review and Monitoring: If the service provider does not conduct regular reviews and monitoring of the restrictive practices as required, the authorisation should be subject to cancellation.

Inadequate Documentation: If the service provider fails to maintain adequate documentation and records of the use of restrictive practices, the Senior Practitioner should have the authority to cancel the authorisation.

Failure to Implement Alternatives: If the service provider does not make reasonable efforts to implement less restrictive alternatives before resorting to restrictive practices, the authorisation should be subject to cancellation.

Breach of Ethical Standards: If there is a breach of ethical standards or guidelines in the use of restrictive practices, the Senior Practitioner should have the power to cancel the authorisation.

Concerns Raised by Stakeholders: If concerns are raised by the individual, their family, or other stakeholders about the use of restrictive practices, the Senior Practitioner should investigate and have the authority to cancel the authorisation if necessary.

By including these additional grounds, the framework can help ensure that restrictive practices are used responsibly and that the rights and well-being of individuals are protected.

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

MHCC propose that any decision made solely by an APO should first undergo an internal review by the Senior Practitioner. Additionally, any decisions made by the Senior Practitioner should be subject to an external review by NCAT.

The benefits of an Internal Review are that:

- Internal reviews can provide a quicker resolution to concerns, allowing for timely adjustments to authorisation decisions.
- They are generally less costly and resource-intensive compared to external reviews.
- The process can help identify areas for improvement within the organisation, leading to better practices and policies.

The potential risks are that:

- There may be concerns about the impartiality of internal reviews, as they are conducted within the same organisation that made the original decision.
- Internal reviews might have a limited scope and may not address all concerns comprehensively.

The benefits of an NCAT Review are that:

- NCAT provides an independent and impartial review, which can enhance trust and confidence in the decision-making process.
- NCAT can conduct a thorough and comprehensive review, considering all relevant factors and evidence.
- The involvement of a legal body ensures that decisions comply with relevant laws and regulations.

The potential risks are that:

- External reviews can be time-consuming, potentially delaying implementation of necessary restrictive practices or ceasing unnecessary practices.
- The process can be more costly compared to internal reviews, both for the individuals involved and the organisation.

This proposal aligns with the DRC recommendation 6.35(b), which advocates that all decisions to authorise restrictive practices should be subject to independent review. By implementing this two-tiered review process, we can ensure greater accountability, transparency, and protection of the rights and safety of people living with disabilities. Having both internal and external review mechanisms provides a balanced approach, in that internal reviews offer a quick and cost-effective way to address concerns, while NCAT reviews provide an independent and comprehensive oversight.

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?

Service providers should be afforded the right to seek a review of a decision. However, this process must be conducted in consultation with the person affected or a person concerned for their welfare. This approach ensures that the rights and perspectives of the individual are prioritised and respected, while also allowing service providers to address any concerns or disagreements regarding the decision in a transparent manner.

The rights to seek review should not be limited solely to the person or a person concerned for their welfare. Including the service provider in the review process can be beneficial for several reasons:

The benefits of including service providers in a review process are:

- Service providers often have detailed knowledge of the individual’s needs and the context in which restrictive practices are used. Their input can provide a more comprehensive perspective.
- Allowing service providers to seek review of decisions can promote accountability and transparency and ensures that all parties involved have a voice and can raise concerns if they believe a decision is not in the best interest of the individual.
- Service providers can identify and highlight potential issues or areas for improvement in the authorisation process, leading to better practices and outcomes.

However, certain safeguards and considerations should be considered:

- Clear guidelines should be established to manage potential conflicts of interest. Service providers should not seek reviews solely for convenience or to avoid implementing less restrictive alternatives.

- The review process should balance the rights and perspectives of the individual, their advocates, and the service providers to ensure fair and just outcomes.
- Service providers should be required to provide detailed documentation and evidence to support their request for a review. This ensures that the review process is based on factual information and thorough analysis.

Including service providers in the review rights can enhance the overall effectiveness and fairness of the authorisation process. It ensures that all relevant perspectives are considered, leading to more informed and balanced decisions.

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

In upholding a trauma-informed, recovery oriented, human rights-based approach to practice, a person should have the right to request a review of their BSP at any time. This ensures that plans remain person-led and protects the autonomy and self-determination of people.

A person should have the right to request the service provider review the BSP at any time for a number of reasons:

- People's needs and circumstances can change over time. Allowing for reviews ensures that the BSP remains relevant and effective in addressing the individual's current situation.
- Giving individuals the right to request a review empowers them to take an active role in their own care and support. It respects their autonomy and ensures their voice is heard.
- Regular reviews can help identify areas for improvement in the BSP, leading to better outcomes for the individual. It also allows for the incorporation of new strategies and interventions as needed.
- If a BSP is not working as intended or if there are concerns about the use of restrictive practices, a timely review can help address these issues promptly, ensuring the individual's safety and well-being.
- Reviews can involve input from various stakeholders, including family members, caregivers, and other professionals. This collaborative approach can lead to a more comprehensive and effective BSP.

However, certain safeguards and considerations should be considered:

- There should be a clear and accessible process for requesting a review, including how requests are submitted and how they will be addressed.
- Service providers should respond to review requests in a timely manner to ensure that any necessary adjustments to the BSP are made promptly.
- All review requests and the outcomes of the reviews should be thoroughly documented to ensure transparency and accountability.

By allowing individuals to request reviews of their BSP at any time, the framework can ensure that the plans remain dynamic, responsive, and person-led.

DCJ 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.

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

The Senior Practitioner should have the authority to handle and investigate complaints regarding the misuse of restrictive practices both on receipt of a complaint and on their own motion.

On receipt of a complaint the benefits would include:

- Ensuring that any concerns raised by individuals, their families, or other stakeholders are promptly addressed.
- Promoting transparency and building trust in the system, as people know their complaints will be taken seriously and investigated thoroughly.
- Holding service providers accountable for their actions, identifying any misuse of restrictive practices and rectifying the actions.

On Its own motion would also be of benefit because:

- This allows the Senior Practitioner to proactively investigate potential issues without waiting for a complaint to be lodged. It can help identify systemic issues and prevent misuse before it occurs.
- It enables the Senior Practitioner to conduct regular audits and reviews, ensuring that restrictive practices are used appropriately and in line with established guidelines.
- It demonstrates the independence and authority of the Senior Practitioner, reinforcing their role as an impartial overseer of restrictive practices.

A combined approach also can be demonstrated to have benefits:

- Combining both approaches ensures a comprehensive oversight mechanism that can address both individual complaints and broader systemic issues.
- It provides the flexibility to respond to immediate concerns while also allowing for proactive investigations to maintain high standards of practice.
- This dual approach enhances the protection of individuals by ensuring that all potential misuse of restrictive practices is thoroughly investigated, regardless of how it comes to light.

In our view by empowering the Senior Practitioner with both complaints handling and investigation functions, the framework can ensure a robust and effective oversight mechanism that promotes the ethical and appropriate use of restrictive practices.

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

We agree that the Senior Practitioner should have the proposed powers to respond to the misuse of restrictive practices. These powers are essential for ensuring the ethical and appropriate use of restrictive practices. The reasons for this are:

Direct the Provider benefits are:

- The ability to direct providers to take or cease specific actions allows for immediate intervention to protect individuals from harm.
- This power enables the Senior Practitioner to provide clear guidance and support to providers, helping them comply with best practices and legal requirements.

Cancel an Authorisation benefits are:

- The power to cancel authorisations ensures that providers are held accountable for their actions and that any misuse of restrictive practices is promptly addressed.
- This power helps protect the rights and well-being of individuals by ensuring that restrictive practices are only used when absolutely necessary and in accordance with established guidelines.

Refer the Matter benefits are:

- Referring matters to the NDIS Commission, police, or other relevant entities ensures that all potential issues are thoroughly investigated and addressed.
- This power promotes collaboration between different regulatory and enforcement bodies, enhancing the overall effectiveness of the oversight system.

By empowering the Senior Practitioner with these authorities, the framework can promote ethical, safe, and appropriate use of restrictive practices. The proposed powers provide a robust framework for responding to the misuse of restrictive practices, ensuring that individuals are protected and that providers are held to high standards of practice.

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

To effectively manage interaction with the NDIS complaints framework there must be clear delineation of roles and responsibilities. The framework must clearly define the roles and responsibilities of the Senior Practitioner and the NDIS Quality and Safeguards Commission. This clarity will help avoid confusion and ensure that each entity can operate within its designated scope, providing efficient and effective responses to complaints.

Further, service providers need to be well informed about the relevant complaints process and know exactly where their service users should be directed to submit complaints or feedback. This includes providing clear, accessible information to service users about how and where to lodge complaints, ensuring that their concerns are addressed promptly and appropriately.

Managing the interaction with the NDIS complaints framework effectively is crucial for ensuring that concerns about restrictive practices are addressed promptly and appropriately. Some key considerations include:

Clear Communication Channels

- Establish clear processes for how complaints related to restrictive practices will be handled within the NDIS framework. This includes outlining the steps for lodging a complaint, the investigation process, and the resolution.
- Ensure that information about how to make a complaint is easily accessible to all stakeholders, including individuals with disabilities, their families, and service providers.

Coordination and Collaboration

- Hold regular meetings between the Senior Practitioner and the NDIS Commission to discuss ongoing issues, share insights, and coordinate responses to complaints.
- In cases where complaints involve both restrictive practices and other NDIS-related issues, consider joint investigations to streamline the process and ensure comprehensive oversight.

Data Sharing and Reporting

- Implement shared databases or reporting systems that allow for the seamless exchange of information between the Senior Practitioner and the NDIS Commission. This can help track complaints, monitor trends, and identify systemic issues.
- Establish regular reporting mechanisms where the Senior Practitioner provides updates to the NDIS Commission on the status and outcomes of complaints related to restrictive practices.

Training and Support

- Provide training for staff within both the Senior Practitioner's office and the NDIS Commission on the specific requirements and nuances of handling complaints related to restrictive practices.
- Offer support services for individuals making complaints, including advocacy services, to ensure they understand the process and their rights.

Independent Oversight

- Consider involving independent bodies to review the handling of complaints periodically. This can help ensure transparency and accountability in the process.
- Implement feedback mechanisms where individuals can provide input on their experience with the complaints process, helping to identify areas for improvement.

By implementing these measures, the interaction with the NDIS complaints framework can be managed effectively, ensuring that complaints about restrictive practices are addressed in a timely, transparent, and fair manner.

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 with any bodies that would facilitate a thorough and clear investigation. This could include, but is not limited to, the NDIS, healthcare providers and services, Police, child protection services, educational institutions, age care providers, advocacy organisations, regulatory bodies and any other bodies that play a role in the protection and support of individuals with disabilities.

There should be clear, documented processes for requesting and sharing information between the Senior Practitioner and these bodies. These processes could be similar to Chapter 16A requests under the *Children and Young Persons (Care and Protection) Act* 1998, ensuring that information sharing is conducted in a structured, transparent, and legally compliant manner.
The circumstances for information sharing include:

- **Safeguarding** Concerns: When there are concerns about the safety and well-being of an individual, information should be shared to prevent harm and ensure appropriate interventions.
- **Compliance and Oversight:** To monitor compliance with legal and regulatory requirements and to ensure that restrictive practices are used ethically and appropriately.
- **Coordination of Care:** To facilitate the coordination of care and support across different service providers and settings.
- **Investigations:** During investigations into the misuse of restrictive practices, information sharing is essential to gather evidence and ensure a thorough review.
- **Legal Obligations:** When there are legal obligations to share information, such as mandatory reporting requirements or court orders.

However, consideration to safeguards for information sharing must include robust processes in relation to:

- **Confidentiality and Privacy:** Ensure that information sharing complies with privacy laws and regulations.
- **Consent:** Where possible, obtain the consent of the individual or their legal representative before sharing information, unless it is unsafe or inappropriate to do so.
- **Need-to-Know Basis:** Share information only on a need-to-know basis and ensure that only relevant information is shared.
- **Documentation:** Maintain clear records of what information is shared, with whom, and for what purpose.

By establishing clear guidelines and safeguards for information sharing, the framework can ensure that the Senior Practitioner can effectively oversee and regulate the use of restrictive practices while protecting the rights and privacy of individuals.

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?

Sufficiency of Proposed Means:

- The proposed means should ensure comprehensive visibility if they include regular reporting, audits, and real-time data access. However, the effectiveness depends on the implementation and adherence by providers.

Additional Information for Reporting:

- Detailed incident reports, including context and outcomes.
- Regular updates on the implementation of behaviour support plans.
- Feedback from participants and their families on the use of restrictive practices.

Minimizing Reporting Burden:

- Implementing automated reporting systems to reduce manual data entry.
- Streamlining reporting requirements to focus on critical data points.
- Providing training and support to providers to ensure efficient and accurate reporting.

These measures could help balance the need for oversight with the practicalities of reporting.

Further Comment

MHCC has heard from some advocates that inadequate thought has been given to reviewing the consent-based and guardianship model approach that has existed for 30 years; and are concerned about a new authorisations system that requires decisions about restrictive practices be made by or under the scrutiny of a Senior Practitioner. In view of current reforms under discussion in relation to the *Guardianship Act 1987* in NSW, which we hope will include the introduction of enhanced **supported decision-making** to strengthen the role of people with disability in making restrictive practices decisions; we would encourage further review and consultation with people with lived experience, their carers, families and service providers to consider the strengths and weaknesses of both the existing and the new proposed senior practitioner model.

Conversely, we understand that Public Guardians and many advocates from across the country have supported a Senior Practitioner model as an independent statutory authority (noting it was the recommended approach from the Disability Royal Commission Report). However, each jurisdiction's legislation is different, and they have differing adult safeguarding frameworks (and most don't have an NSW Ageing and Disability Commission (ADC) equivalent). So, no common view was expressed on where such a function would sit.

We propose that if this Restrictive Practices Legislative Framework is to proceed, the safeguard of oversight by an independent body such as ADC is essential. Our understanding is that the Central Restrictive Practices Team has been co-located with the ADC in NSW since 2020, ahead of the anticipated introduction of the Bill to Parliament. If the ADC were to take on that additional role they would need to be appropriately funded as they are seriously under resourced.

MHCC note that the new *Age Care Act 2024* (Cth) will come into effect 1 July 2025. Section 163 of the Act provides immunity from civil or criminal liability for registered providers using restrictive practices under certain conditions. However, this immunity will no longer apply after December 1, 2026, [22],[23].

This change means that aged care providers will need to be more cautious and ensure they comply with all relevant regulations and consent requirements when using restrictive practices. To reflect the amendment in the proposed Restrictive Practices Legislative Framework, MHCC urge consideration of the following steps:

- **Update Legal Text:** Amend the legal text to explicitly state that the immunity provided under Section 163 will no longer apply after December 1, 2026. This should be clearly mentioned in the relevant sections of the framework.

- **Compliance Requirements:** Introduce detailed compliance requirements for aged care providers. This includes ensuring that all restrictive practices are documented, justified, and reviewed regularly to meet the new legal standards.

- **Training and Education:** Implement mandatory training programs for staff on the updated legal requirements and best practices for using restrictive practices. This will help ensure that all personnel are aware of the changes and know how to comply.

- **Monitoring and Reporting:** Establish robust monitoring and reporting mechanisms to track the use of restrictive practices. This could involve regular audits and the requirement for providers to report any use of restrictive practices to a regulatory body.

- **Stakeholder Engagement**: Engage with stakeholders, including aged care providers, residents, and their families, to inform them about the changes and gather feedback on the implementation process.

- **Review and Feedback:** Set up a system for ongoing review and feedback to assess the impact of the changes and make further adjustments as necessary.

These steps will help ensure that the legislative framework is updated effectively and that all services including age care providers are prepared for the changes.

The interface between the new *Aged Care Act 2024* and the NSW Restrictive Practices Legislative Framework involves several key aspects for consideration:

- **Compliance with State Laws:** The new *Aged Care Act 2024* requires that restrictive practices in aged care settings comply with state or territory laws, including those in NSW. This means that if the legislative framework s all providers they must align with aged care providers and adhere to both federal and state regulations when implementing restrictive practices[24].

- **Penalties for Non-Compliance:** The new Act includes provisions for penalties and sanctions for providers who fail to comply with the regulations regarding restrictive practices. This is consistent with the NSW framework, which also imposes penalties for non-compliance[25].

By aligning these key aspects, the new Aged Care Act and the NSW Legislative Framework for Restrictive Practices will work together to protect the rights and well-being of individuals in any aged care setting.

Concluding Acknowledgement

MHCC thanks all its members and the other interested stakeholders who generously provided their input to this submission. We also express our appreciation to the Department of Health and Aged Care for the opportunity to share the evidence we have scoped from the literature as well as material gathered from the broader CMO mental health sector.

Please feel free to connect to discuss any details about the issues raised in this paper and future consultation topics with corinne@mhcc.org.au

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References

[1] NDIS Quality and Safeguards Commission, Behavior Support and restrictive practices. Available: https://www.ndiscommission.gov.au/rules-and-standards/behaviour-support-and-restrictive-practices

[2] NDIS Practice Standards Guidebook: An Essential guide for Psychosocial support service providers, and self-audit tool 2022. Available: https://mhcc.org.au/wp-content/uploads/2022/08/Embracing-Change-NDIS-Practice-Standards-Guidebook-v2.pdf

[3] Open Minds, Positive Mental Health Behaviour Supports. Available: https://openminds.org.au/10-key-components-positive-behaviour-support/

[4] NDIS Quality and Safeguards Commission, Available: https://www.ndiscommission.gov.au/resources/reports-policies-and-frameworks/ndis-commission-activity-reports#paragraph-id-6958

[5] Disability Advocacy Network Australia, 2024 *Royal Commission: Analysing the recommendations on restrictive practice.* Available: https://www.dana.org.au/royal-commission-analysing-the-recommendations-on-restrictive-practices/

[6] The University of Sydney 2022, *Children and young people with disability in the child protection and out-of-home care (OOHC) system are a highly vulnerable group and evidence about prevalence*. Available: https://www.sydney.edu.au/content/dam/corporate/documents/faculty-of-arts-and-social-sciences/research/research-centres-institutes-groups/rccf/children-and-young-people-with-disability-in-out-of-home-care_summary-of-the-evidence.pdf

[7] Australian Institute of Health & Welfare 2023, *Child protection Australia 2021–22*. AIHW.

[8] Davis, M. 2019, *Family is Culture: Independent review of Aboriginal Children and young people in OOHC*. Sydney: Department of Communities and Justice.

[9] Miller, H., Truong, M. & Alla, K., 2024, *Supporting children with disability in out-of-home care* (OOHC). Emerging Minds. Available: https://emergingminds.com.au

[10] NSW Ombudsman 2021, *More than shelter - outstanding actions to improve the response to children presenting alone to homelessness services.* Available: https://cmsassets.ombo.nsw.gov.au/assets/Reports/More-than-Shelter_A-progress-report.pdf

[11] Australian Institute of Family Studies (AIFS), 2025, NSW Department of Family and Community Services, & Chapin Hall Center for Children. ***Wave 1 Baseline Statistical Report: Summary Pathways of Care Longitudinal Study: Outcomes of children and young people in out-of-home care in NSW***. *Research Report 2*. Department of Family and Community Services.

[12] Ibid
[13] Ibid

[14] Department of Communities and Justice, Behavior Support Guidelines for OOHC. Available: https://dcj.nsw.gov.au/documents/covid-19/service-providers/additional-information/Behaviour_Support_OOHC_Guidelines.pdf

[15] Australian Institute of Health and Welfare (AIHW) 2024, *Younger people in residential aged care.* [online] Available at: https://www.gen-agedcaredata.gov.au/resources/younger-people-in-residential-aged-care

[16] Recommendation 6.35(b) focuses on the legal frameworks for the authorisation, review, & oversight of restrictive practices. Specifically, it calls for establishing clear legal frameworks & regular review & oversight. This recommendation aims to create a more consistent and accountable approach to the use of restrictive practices across different settings, ensuring the rights and safety of individuals with disabilities are protected.

[17] Age Care Quality & Safety Commission. Available: https://www.agedcarequality.gov.au/older-australians/safety-care/minimising-restrictive-practices

[18] NDIS Quality and Safeguards Commission 2021, *Regulated Restricted Practices Guide*. Available: https://www.ndiscommission.gov.au/sites/default/files/2022-02/regulated-restrictive-practice-guide-rrp-20200.pdf

[19] Ibid

[20] Nankervis K & Vassos M 2023, *Evidence Matters: Developing NDIS Quality and Safeguards Commission Quality Behaviour Support Plans,* Prepared for the NDIS Quality Commission. Available: https://www.ndiscommission.gov.au/sites/default/files/2024-09/Evidence%20Matters%20-%20Developing%20Quality%20Behaviour%20Support%20Plans%20-%20JUNE%202023.pdf

[21] The Wellness Society (n.d), *How Behaviour Support Plans Improve Wellbeing and Quality of Life*. Available: https://thewellnesssociety.org/how-behaviour-support-plans-improve-wellbeing-and-quality-of-life/

[22] Commonwealth Act, *Age Care Act 2024* (No 104, 2024). Available: https://classic.austlii.edu.au/au/legis/cth/num_act/aca202457/s163.html

[23] Above also available; https://www.legislation.gov.au/C2024A00104/asmade

[24] *The evolving landscape of restrictive practices in aged care*. Available: https://csi.nsw.gov.au/content/dam/dcj/ctsd/ncat/documents/speeches/20210312_paper_fougere_c_aged_care_role_of_gd.pdf

[25] *The practicalities of the new Aged Care Act*. Available: https://lsj.com.au/articles/the-practicalities-of-the-new-aged-care-act/

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