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Uniting NSW.ACT Response to the proposed legislative framework for regulating the use of restrictive practices on people with disability

Uniting NSW.ACT contributes to the work of the Uniting Church in NSW and the ACT, through social justice, advocacy, community services and spiritual care. We provide services for people through all ages and stages of life, and drive solutions to systemic issues so people experiencing disadvantage can live their best lives.

We welcome the opportunity to provide comment on the proposed legislative framework on the use of restrictive practices on people with disability. We support over 145,000 people in NSW and the ACT across a variety of services including disability services, mental health, out-of-home-care and aged care. As a result we have extensive experience in supporting clients with disability, including managing and reducing the use of restrictive practices as well as supporting participants who are subject to restrictive practices in other settings outside of Uniting.

We have provided responses to each of the questions within the paper but would like to share our overarching remarks:

- We are concerned that the introduction of Authorised Program Officers (APO) will create a financial burden for providers who provide critical services supporting people with complex needs. If providers are required to fund the cost of an APO, this will make providing services for people with complex needs financially unappealing and exacerbate the ongoing issue where people with complex needs are refused service by providers.
- Independent oversight is critical to ensuring the rights of people with disability and this proposal, as drafted, would remove the critical role of the independent panel and primarily place responsibility with contractors who are selected and paid for by the provider.
- We support the introduction of a Senior Practitioner with the functions proposed within the paper but with the existing panel arrangements. We strongly endorse the proposed oversight, education and regulation functions in particular which would both support providers and protect the rights of people with disability.

Fundamentally, this paper assumes that providers will deliver high quality services and supports and trusts that they will commit to a human rights approach to restrictive practices. The Disability Royal Commission has shown that this is not universally true. Given the failures in the market, the NSW Government should be investing in a more rigorous

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oversight rather than less. We believe that this should be achieved by strengthening the existing panel arrangements including through the introduction of a Senior Practitioner role.

If Uniting can assist you with any further information, please contact Clare Lawrence, Principal Policy Officer at [redacted]

Yours sincerely,

Dr Andrew Montague
Director Communities
Uniting NSW.ACT

A legislative framework to regulate restrictive practices

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

Our general concerns within this paper relating to the independence of APOs are equally applicable to the out of home care setting. We also note that the proposed framework will apply to residential out of home care services which provide significant supports for children with disability in out of home care.

Our primary concern for non-residential out of home care services, is the alignment with the Office of the Children's Guardian (OCG) and the existing regulatory structures which protect the rights of children with disability in out of home care. Changing to this framework would be a systemic change which would need to include reforms across multiple systems and services.

The out of home care system is uniquely positioned and supports some of the most vulnerable children in our community. Any reforms in this space must be targeted specifically at the experiences of these children and there is an inherent risk in applying an approach from one service setting (disability/health/education/justice) to the out of home care system.

We believe that the use of restrictive practices in the out of home care setting requires a nuanced and distinct approach which cannot be fully explored without further information from government.

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

We endorse the proposal to include health settings under the proposed framework. In our experience as a provider, we have witnessed the use of inappropriate and avoidable restrictive practices within hospital settings when our NDIS participants have been hospitalised. We believe that while health services can be working in challenging environments, they should be subject to appropriate oversight and regulation of restrictive practices.

We do not have comment on the inclusion of education or justice settings.

Question 3: What issues and challenges are raised by there being different frameworks for the authorisation of restrictive practices in the disability service provision setting and the aged care setting?

We appreciate the need for different frameworks for regulating the use of restrictive practices in disability and aged care services, given the different funding and oversight responsibilities between state and federal government. Regardless, it continues to create ongoing management and logical challenges for providers like Uniting who deliver both disability and aged care services.

We currently have approximately 40 Younger People in Residential Aged Care (YPIRAC), who are clients within our residential aged care services and are NDIS participants. Information sharing between the NDIA, NDIS Quality and Safeguards Commission, Department of Health and Aged Care and Aged Care Quality and Safety Commission does not occur and so it is difficult for aged care providers to know which residents are YPIRAC

participants. This means that providers are unaware of their obligations to manage restrictive practices differently for these residents.

When the provider is aware, they are required to manage restrictive practices in two different ways and through two different reporting systems which is both ineffective and burdensome.

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, we support these principles.

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

We believe that the principles should reflect the responsibility of the provider to phase out and reduce the use of restrictive practices.

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

We support the recommendation of the Disability Reform Council (2019) to prohibit the use of specific restrictive practices including specific forms of physical restraint and punitive approaches. These should be banned in all settings; we do not believe it is appropriate to use any of these prohibited practices.

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

Yes, we believe it is appropriate to align the NSW legislative framework with the NDIS definitions.

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

Yes, provided this aligns with the guidance provided by the NDIS Quality and Safeguards Commission which also has responsibility for providing information relating restrictive practices.

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

We note that the consultation paper does not currently outline the qualifications for a Senior Practitioner. We believe that this role should be held by a Registered Health Professional such as a Registered Nurse, Registered or Endorsed Psychologist with significant experience in restrictive practices, behaviour support and working with people with disability.

8a: Should the Senior Practitioner have the power to prescribe additional and/or more detailed information for inclusion in the BSP? If so, what information?

We note that this is an existing process within the current panel structures. We support this as a power although we also would like to highlight that the NDIS Quality and Safeguards Commission introduced a template for BSPs in 2024 which is intended to uplift the quality of BSPs.

8b: Should the Senior Practitioner have the power to require a behaviour support practitioner have certain qualifications and the Senior Practitioner's approval before

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

We believe that these are two separate concerns and as such have addressed them separately below.

Qualifications for behaviour support practitioners

We agree that the current self-assessment process relating to behaviour support practitioners is inadequate. The lack of regulation has created a market where behaviour support practitioners are providing plans without appropriate knowledge or skill.

However, we are equally concerned that introducing requirements for behaviour support practitioners without consideration of the implications for the market and workforce would be shortsighted. Our services currently engage high quality behaviour support practitioners including psychologists where waiting lists and availability for appointments can be challenging.

We believe that the introduction of required qualifications/training should be a gradual process done in consultation with disability providers and the allied health sector. It may include required online learning as a starting point before progressing to formal qualifications/training when there is market capacity. We appreciate that this would also require leadership from the federal government who is responsible for the NDIS and provides funding for behaviour support practitioners.

Regulation of behaviour support practitioners

We support the proposal that a behaviour support practitioner must have approval before developing a BSP. This should include confirmation of their registration status with the NDIA and a review of the evidence provided to the NDIA for proof of their eligibility.

8c: Should there be any specific provisions relating to consultation in the development of a BSP, in addition to the requirements in the NDIS Rules?

Yes, people with disability should have the right to be consulted in the development of a BSP.

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

As discussed further within this response, a BSP is only as good as its application. A thoughtfully developed and well structured BSP does not guarantee that it will be utilized appropriately in day-to-day life. For this reason, we endorse the role of the Senior Practitioner to have oversight and education functions.

Question 10: Should APOs be empowered to either:

Before considering the proposed functions of the APO, we would like to outline our objection to the introduction of the APO model as proposed in this paper. We believe that it increases the risk to participants, removes independent oversight and presents a significant conflict of interest in allowing a provider to employ a person who provides authorisation for restrictive practices within their service.

The Royal Commission recommended that states and territories introduce a Senior Practitioner who should be responsible for authorising the use of restrictive practices in disability settings. It did not mandate the use of APOs as a secondary authority and there is no requirement for the Senior Practitioner to delegate approval to other parties.

Independence and conflict of interest

Allowing a service provider to select and fund an APO to approve their use of restrictive practices would create a significant conflict of interest. This removes independence and presents the risk that APOs are inadvertently influenced to approve the inappropriate use of restrictive practices given that they are paid by the provider directly. This is an unacceptable risk which removes oversight and allows providers to manage the approval of restrictive practices "in house".

Cost and unintended consequences

The disability sector is already facing concerns regarding financial viability and sustainability. Introducing a requirement for providers to fund APOs places an additional burden on providers and would require that this expense be met through cost cutting in other areas.

Additionally, this would create a disincentive for providers to accept people with disability with the most complex needs and who require restrictive practices to ensure their safety. These clients are already facing challenges accessing services, particularly as the government is no longer acting as a provider of last resort. If delivering services for this cohort requires additional unfunded expenses for providers, these clients will be exited or not accepted for services.

10a: 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?

The very definition of a restrictive practice is that it restricts the rights or freedom of movement for a person with disability, almost always without their consent. There is no category of restrictive practice where it would be appropriate for approval to be given only from a person who is employed by a private provider.

10b: 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?

If the APO model was introduced, this would be our preferred approach as it would ensure that there is some independent oversight on the approval of restrictive practices.

We recognise that this will introduce double handling and duplication given that approval would need to be provided by both the APO and Senior Practitioner. We believe that this is necessary to avoid the potential for providers to influence the approvals process.

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

Our preferred approach would be to integrate the role of the Senior Practitioner while enhancing the existing panel approach. This would include:

- Introducing the role of Senior Practitioner with education, guidance, complaints and oversight functions including the ability to instigate an own motion inquiry independent of government.
- Maintaining the existing panel approach including the requirement to have a specialist with expertise in behaviour support who is independent of the service provider.
- Introducing the right for people with disability and their supports to request a review of the decision to approve a restrictive practice including through internal review by the Senior Practitioner and external review by NCAT.

We believe that the role of Senior Practitioner would be an important addition to the regulation of restrictive practices and would contribute to the overall objective of reducing and eliminating the use of restrictive practices. However this should complement, rather than replace the existing panel arrangements.

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?

If the APO role was introduced, it would not be practical for an APO to only be employed by a single provider. Some providers (including Uniting) do not have the client base to justify employing an APO on even a part-time basis. Other providers also have deliberately small participant numbers as they provide specialist services such as complex behaviour support or serve a specific cohort such as culturally and linguistically diverse or First Nations communities.

It is unclear if there would be the workforce capacity to have an APO for each provider delivering services to participants with restrictive practices and it would be unlikely to be appealing if each could only be employed by a single provider. This would also significantly disadvantage smaller providers who would be unable to attract similar talent to larger providers who would have increased caseloads and therefore work available.

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

We support the proposed duration but believe that each decision should be made in consultation with the person and provider.

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

We support the proposal for the Senior Practitioner to have the ability to cancel an authorisation.

We would appreciate further information into the proposed investigations function for cancelling a restrictive practices authorisation. Before cancelling an authorisation, the Senior Practitioner (or their delegate) should be required to speak to the person or their representative, the provider and the behaviour support practitioner.

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 have the right to request a review into a decision not to authorise a restrictive practice. This may include the opportunity to provide further information or insight into why they believe a practice should authorised.

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

Yes we agree with this proposal. We believe that this right should also be extended to any person who is concerned for their welfare, in keeping with the right to review discussed above. This would enable others including family, advocates and other supports to request a service provider review a BSP.

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

Yes, the Senior Practitioner should have both functions and should be able to act both on receipt of a complaint and on its own motion. This is critical for ensuring that own motion inquiries are not dependent on approval from government.

This should also include investigating referrals from the Ageing and Disability Commission (ADC) Helpline where a person reports concerns about the use of restrictive practices. Wherever possible, the ADC and Senior Practitioner investigation staff should work together to share information to enable both to take appropriate action.

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

Yes, this additional oversight would be welcomed.

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

The interaction between the NDIS complaints framework and proposed NSW framework should be aligned as far as possible. This should include an information sharing Memorandum of Understanding and procedure for ensuring that critical information is shared between the bodies.

We are concerned that there is the potential that the reporting and investigation processes will be duplicated between the Senior Practitioner and NDIS Commission, leading to an increased burden on providers. The NSW Government should ensure that this is minimized as far as possible to promote an effective working relationship between providers, the Senior Practitioner and NDIS Commission.

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?

Given the importance of the ADC as a safeguard for people with disability, both through the public Helpline and Official Community Visitors (OCV) scheme, there should be information sharing and referral pathways between the Senior Practitioner and ADC.

This is critically important given that OCVs have the power to raise concerns relating to the use of restrictive practices including ensuring appropriate consent, authorisation and review. When this issue is raised with a provider, the information should be automatically shared with the Senior Practitioner. This would enable the Senior Practitioner to monitor concerns raised by OCVs and take action if appropriate including undertaking an investigation or cancelling authorisation for a restrictive practice.

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?

We believe that there is a role for reporting as a mechanism for overseeing the use of restrictive practices but this data collection and reporting must be useful, relevant and insightful. Reporting for the sake of reporting does not provide benefit but rather creates

a burden both for the provider and regulatory body.

As far as possible, the reporting requirements for the NDIS Commission and Senior Practitioner should be aligned and streamlined. Information sharing between the two bodies should be an immediate priority for government.

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

Yes, we believe that this would contribute to the reduction and elimination of the use of restrictive practices. This education and guidance should align with the information provided by the NDIS Commission.

Question 24a: Should the Senior Practitioner have the power to impose sanctions for the misuse of restrictive practices, or are existing sanctions for misuse of restrictive practices sufficient?

We support the proposed powers and agree that there is a role for the Senior Practitioner to impose sanctions for the misuse of restrictive practices.

24b: How should the interaction between sanctions provided for under NDIS legislation and the proposed framework be managed?

As we have discussed previously, there should be information sharing between the two bodies to ensure that all stakeholders have a clear understanding of sanctions applied to both providers and individuals. For example, if a person is subject to a banning order by the NDIS Commission they should automatically be excluded from acting as an APO. Providers should also have the ability to request information from the Senior Practitioner if an APO has previously been subject to 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 this is critical for ensuring that providers are able to deliver services to people with disability. Without this legislated immunity, there is a risk that providers will discontinue services for people with disability with complex needs.

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

No additional response.

General comments

The importance of workforce

Reducing the use of restrictive practices is only possible with a committed, skilled and knowledgeable workforce with strong relationships with the people they support. The increased use of casual staff within the disability sector prevents people with disability from forming meaningful connections with their support staff.

These relationships are essential for supporting the reduction of restrictive practices by ensuring that staff have a comprehensive understanding of the person's needs and indicators for escalated behaviours which may require the use of restrictive practices. This knowledge enables them to proactively use the strategies within the BSP to de-escalate and prevent the need for restrictive practices wherever possible.

Further, there is an urgent need to invest in training to support a reduction in the use of restrictive practices. We note that in jurisdictions such as Ireland, New Zealand and the UK there has been a very deliberate move away from restrictive practices such as seclusion, chemical and physical restraint in the mental health and disability areas of health across the past 20 years. This was supported by an uplift in research, education and the creation of specialty roles such as Nurse Educators and thus a noticeable reduction in restrictive practices.

At Uniting, we are committed to ensuring that our clients are supported to have ongoing and consistent relationships with the disability support workers who support them in our group home settings. As a result, we have seen a demonstrated benefit for our participants and an overall reduction in the use of restrictive practices. This has also been as a result of our training programs which focus on a human rights approach to disability services and prioritise the voice of the participant.

While we welcome the efforts to reform the restrictive practices framework, we encourage the NSW Government to consider the role of the workforce in implementing these practices and support broader investment in the sector.