



Submission on the Persons with Disability (Regulation of Restrictive Practices) Bill 2021

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Who is the Physical Disability Council of NSW?

The Physical Disability Council of NSW (PDCN) is the peak body representing people with physical disabilities across New South Wales. This includes people with a range of physical disability issues, from young children and their representatives to aged people, who are from a wide range of socio-economic circumstances and live in metropolitan, rural and regional areas of NSW.

Our core function is to influence and advocate for the achievement of systemic change to ensure the rights of all people with a physical disability are improved and upheld.

The objectives of PDCN are:

- To educate, inform and assist people with physical disabilities in NSW about the range of services, structure and programs available that enable their full participation, equality of opportunity and equality of citizenship.
- To develop the capacity of people with physical disability in NSW to identify their own goals, and the confidence to develop a pathway to achieving their goals (i.e. self-advocate).
- To educate and inform stakeholders (i.e.: about the needs of people with a physical disability) so that they can achieve and maintain full participation, equality of opportunity and equality of citizenship.

Introduction

As the peak representative body for people with physical disability within NSW, the Physical Disability Council of NSW appreciates the opportunity to review and comment on the *Persons with Disability (Regulation of Restrictive Practices) Bill 2021*.

Restrictive practices are used in the ordinary management of people with disabilities across many contexts.

Restrictive practices need to be recognised as antithetical to the fundamental rights of people with disability - restricting an individual's physical freedom, their right to personal autonomy and their personal dignity. These practices can be dehumanising, but also potentially physically and psychologically dangerous. These practices can come precariously close to acts of recognised criminality such as physical assault.

Consistent with our international commitments under the United Nations Convention on the Rights of Persons with Disability (the UNCRPD), Australia should work towards heavily restricting and regulating the use of any form of restrictive practice.

To that end, we appreciate the efforts of the Department of Communities and Justice in providing a framework around the use of restrictive practices which emphasises the rights of people with disability to determine the parameters in which restrictive practices may or may not be part of their behavioural support plans.

We understand and appreciate that there will be instances in which a person with disability may require intervention to prevent them from harming either themselves, or others. Whilst we would hope to eliminate restrictive practices as a behaviour modification tool all together, we are pragmatic in recognising that these practices may have a place in specific contexts, where all other behavioural management techniques have been exhausted, with the express and informed consent of the individual or their appointed representative, using the least restrictive method possible across the shortest possible timeframe.

We can see that the Bill provides greater clarity on the underlying principles that should govern the use of restrictive practices, removes some worrying exemptions, such as those relating to '*non-intentional risks*' and creates more structure around mechanism for oversight and review.

The Bill also creates a useful framework to appoint authorised decision makers when an individual cannot express consent themselves and will standardise practice across NDIS providers and State Government departments in alignment with the *National Restrictive Practices Authorisation Principles*.

At the same time, there are some aspects of the Bill that, in our minds, go against its express purpose, resulting in "gaps" across the protection of vulnerable people who may be subject to restrictive practices.

One such example is can be seen in the retention of lengthy interim and comprehensive authorities – the other in the Act’s handling of emergency situations under Cl. 11. We have outlined our concerns and would be willing to elaborate on our concerns in more detail, should this be useful.

Responses to the Questions Posed

PDCN's responses to the questions posed in the position paper can be found below.

Q1. Do you agree with the proposed objects and principles of the Bill?

It is essential that the proposed objectives and principles of the Bill align with our international commitments under the UNCRPD.

We are satisfied that the objects and principles of the Bill achieve this, emphasising that restrictive practices should only be employed in exceptional instances subject to stringent checks and balances, in the least restrictive manner, for the shortest possible time.

We are particularly satisfied with the assumption that a person will, *prima facie*, be assumed to be capable of providing consent unless there is evidence to the contrary and that *all* reasonable steps should be taken to assist them in being able to provide consent.

The use of the term "all" is critical because it requires that all possible efforts are exhausted before the individual loses the right to consent.

Q2. Is the reporting framework for NSW Government agencies sufficiently robust?

Reporting will be an essential part to tracking the progress of the legislation in realising its objectives and principles.

Given the very serious purpose of the Bill and the fact that current prescriptive instruments do not appear adequate in safeguarding the rights of people with disabilities, it is imperative that a robust reporting mechanism is developed to monitor the resulting Act's efficacy.

It is difficult to comment on the nature of the reporting framework without seeing the regulations. We think that it is appropriate that the reporting will include details on how the objects and guiding principles have been considered as they extend to services directly administered by government or via a body engaged by Government.

We are very uncomfortable with the idea that the regulations may exempt a relevant government sector agency, or a class of relevant government sector agency, from a requirement to include specified information or to address specified matters in a report and do not support such a rule.

We also consider that there is a responsibility across departments and other Government Agencies to provide transparency across specific instances of when restrictive practices have been applied, the nature of the specific practice utilised and any other information that allows the application of restrictive practices to be externally monitored and tracked in a way that protects the privacy of the individual concerned.

Such information could provide a basis for the Commission to work with Departments, identifying and responding to trends within specific departments, identifying departments where extra resources should be directed to assist in the realising of the Acts as well as tracking the Act's intended purpose of reducing the overall use of restrictive practices.

Our view is that departments and agencies should need to regularly report across all information that is relevant to the Commission performing its functions under Part 2, Cl 5 as well as satisfying general principles of Government transparency and accountability.

Q3: Do the Ageing and Disability Commissioner's new responsibilities support the appropriate use and review of restrictive practices?

PDCN considers that the new responsibilities appear to cover all relevant functions we would expect the Commission to exercise in the administration of the Act.

We are particularly happy to see that the Commissioner has been given sufficient authority to review decisions and revoke authorisations, and that Commonwealth NDIS agencies and NSW Government sector agencies are required to co-operate with the Commissioner in the fulfilment of the Commissioner's duties.

We consider that the responsibility to co-operate with the Commissioner's enquiries should extend to any provider of supports to persons with disability under the NDIS scheme, not just to Commonwealth NDIS agencies and NSW Government sector agencies and that this would better reflect the Act's intentions in regulating and overseeing the use of restrictive practices across the scheme as a whole.

Likewise, the Commissioner should have the power to compel individuals in the course of their employment within NDIS provider organisations to provide information to assist in his enquiries relating to the review of authorisation panel decisions and note that it may be relevant to extend these powers even more broadly (in compliance with relevant privacy legislation) to other groups, including treating health professionals etc.

We note that such broad ranging powers are already provided across a range of government review agencies in order to facilitate thorough investigations.

Q4: Is the framework for the gaining the NDIS participant's consent sufficiently robust and practical?

It would be beneficial to provide more clarity around the nature of the information that needs to be provided to the individual, the mechanisms for communicating that information, and at what point an NDIS provider should be satisfied that the individual is incapable of providing consent themselves.

What we ultimately want is for the individual to be given every possible opportunity to give full and informed consent.

Every effort should be made to communicate via accessible means that are appropriate to the individual. This may involve the use of communication aids, interpreting, AUSLAN, pictures or storyboards to both communicate information about the restrictive practice and to determine whether the individual consents to it.

We note that this is touched on to an extent in determining whether a person withdraws or refuses a restrictive practice where it is stated that:

(3) Without limiting the circumstances in which an NDIS participant is taken to refuse or withdraw consent, an NDIS participant is taken to refuse or withdraw consent to the use of a restrictive practice if the NDIS participant—

(a) indicates, by whatever means, that the NDIS participant does not want the restrictive practice to be used,

Obviously, we consider that the benchmark for determining that a person consents should be much higher – there must be no doubt at all that the individual agrees to the restrictive practice procedure.

Key to a person being able to give full and informed consent is a thorough understanding across various aspects of the restrictive practice itself.

The Bill states that an individual needs to understand the general nature and the effects of the restrictive practice. PDCN advocates for a more specific, non-exhaustive range of issues that should be expressly communicated to the individual, as a necessary part of the consent process including:

- The nature of the specific form of restrictive practice,
- Possible risks associated with its use, including health risks;
- The expected duration that the person may experience restriction;
- The reason/s why the restrictive practice is viewed necessary;
- Who will administer the restrictive practice; and
- What the individual might expect to experience while undergoing the restrictive practice;
- That the individual can withdraw consent at any time and the procedure must then cease.

Likewise, we would expect to see clarity on information that a service provider should rely on when determining the individual's capacity to consent, and a requirement that any line of reasoning used is clearly documented.

The Commissioner should have the right to access this information as part of his investigative powers.

Whether the individual has capacity to consent is fundamental to being able to appropriately comply with relevant sections of the Act.

We would recommend that the Act provides a non-exhaustive list of factors to be considered when determining whether an individual can/or cannot give consent, including, but not restricted to:

- Information provided by carers, friends and other people with whom the individual has an intimate relationship.
- Information from people who ordinarily provide care and other supports to the individual, e.g. support workers.
- Information provided by treating health professionals; and
- Any relevant medical documentation specific to the individual's capacities;
- Any guardianship orders, current or otherwise, pertaining to the individual;

The individual's capacity should always be determined on a case-by-case basis. Assumptions should not be made based on the general nature of an individual's disability or disabilities.

It should be acknowledged that a person's capacity to provide consent may vary. As part of this, a service provider should regularly revisit the question of whether consent can be provided by the individual at different points in time.

Q5: Do you think the Bill provides enough support for people with disability to make decisions for themselves?

Currently we have concerns in relation to this.

The Act should prescribe what information a provider must give an individual so they can make an informed choice.

While the Act is clearly framed with the intention of ensuring that people with disability can exercise their rights relating to the use of restrictive practices, there is insufficient focus on how to achieve this.

It is vital that the person with disability exercises a full and informed choice.

Critical to this, a service provider must accessibly communicate to the individual all relevant information regarding the restrictive practice procedure.

We do not think that providing details of the general nature and the effects of the restrictive practice is sufficient to establishing this benchmark. We would instead propose that the Act gives a more specific, non-exhaustive range of considerations that must be communicated to the individual, as necessary to gaining consent:

- The nature of the specific form of restrictive practice,
- Possible risks associated with its use, including health risks;
- The expected duration of the restrictive practice,
- The reason/s why the restrictive practice is viewed necessary;
- Who will administer the restrictive practice; and
- What the individual might expect to experience while undergoing the restrictive practice activity;
- That they can withdraw consent at any time and the administering agency must stop the procedure

The individual should have the right to seek their own external advice, and where practicable, should have sufficient time to make an informed choice.

An individual should be fully involved in the development of their behavioural support plan

Individuals should also be fully involved in the process of developing behaviour support plans, where it is anticipated that restrictive practices may form part of such a plan and be given any necessary supports to do so.

We do not support the inclusion of interim and comprehensive authorities for the use of restrictive practices. Consent should be sought (and duly given) in each instance.

We are hugely troubled by the inclusion of interim and comprehensive authorisations, which provide for an assumption of consent, unless the individual expresses otherwise.

While we understand why comprehensive or interim authorities might be efficient in the context of providing support to an individual, we cannot support anything that rests on pre-emptive consent for any activity that could violate an individual's right to bodily autonomy.

Express consent from an individual should be sought *in each and every instance* where it is deemed necessary to apply a restrictive practice, since the process of withdrawing consent verses giving consent are very different.

At the point that a restrictive practice may be applied, it is highly likely that the individual will be distressed, anxious, vulnerable and overwhelmed. The individual may feel obligated to comply with the directives provided by support provider staff as a response to the power dynamic that often exists between providers and those who receive support.

It could be all too easy, in such a context, for an individual to assume that they are bound by an interim or comprehensive authority regardless of whether they want the process performed in that instance or not. They may not know, or comprehend at the time, that they have the right to revoke consent.

At the same time, 12 or even 6 months is a significant amount of time for an individual to express a prima facie intention to allow themselves to be subject to restrictive practices.

How a person feels at any point in time is subject to the specific circumstances – people can, and often do, change their minds. People's views and attitudes can also shift, or their capacity to reason and understand might change.

To address these issues, it is imperative that any support provider looking to use restrictive practices seeks consent each and every time.

This is the only way to know with certainty that the individual's rights are being respected.

Q6: Are there any other safeguards that should be put in place around the trusted person framework?

The paramount consideration is that any person appointed to provide consent on behalf of the individual is acting in the best interests of that individual.

Having a framework around defining appropriate trusted persons to provide consent if the individual cannot, is highly useful.

The current structure is sufficiently robust in that it provides the capacity to bypass a person if the individual does not want this person to act as authority or if there is any other reason why this person may not be appropriate – in this instance the sorts of scenarios that immediately spring to mind for us are circumstances where there may be domestic violence or elder abuse.

To comprehensively manage this issue of consent when the individual is unable to provide it themselves, the Act should also prescribe how a trusted person could have their authority revoked.

We also consider that it would be useful to provide instruction when it is not possible to find someone who can fulfil that role – as stated previously, we consider that there may be scope for referral to the NCAT Guardianship Tribunal in such instance.

[Q7: Does the draft Bill provide enough opportunities for people with disability, and their support people, to be involved in the decision-making process?](#)

There are several key points in which decision making is exercised across the Act and it is critical that the individual and their support people can be involved across each of these processes. These points are:

- when a restrictive practice is about to be applied;
- during a restrictive practice;
- in the drafting of a behaviour support plan;
- in decisions regarding the appointment of a trusted person to provide consent on behalf of the individual

The Bill provides a good structure for ensuring that the individual is involved (where they can be) in decision that may either directly involve, or result in, the use of restrictive practices.

It also clearly sets out the expectation that the individual has the prima facie right to make decisions on these issues.

[Q8: Does the authorisation framework provide enough balance between the rights of the person with disability and the responsibilities of their service provider?](#)

The onus should fall on the service provider to ensure that the objects of the Act are met. This is appropriate given the nature of the relationship between an individual and a provider, and the relative knowledge, resources and powers of the parties.

The relationship should be fiduciary in nature, with the service provider legally and ethically bound to act in the best interests of the individual. Human rights are paramount, and it is the

responsibility of the service provider to ensure that every effort is made to ensure that the individual can realise their rights.

Interim and comprehensive authorities are disproportionate in that they facilitate the quick and easy management of individuals. Authorities may be efficient and useful when managing the behaviour of an individual in, but any organisational benefits must be considered in the context of the disproportionate harm the individual might experience when subject to an authority.

Q9: Are the Commissioner's and NCAT's powers to review restrictive practices sufficient?

As stated, we appreciate the fact that the Ageing and Disability Commissioner has been provided the power to review decisions of an authorisation panel and to revoke authorities as appropriate. This is far preferable to models where review bodies cannot make binding decision and are limited to making recommendations.

We understand that the Commissioner will review the decisions of an authorisation panel, and that NCAT can review the decisions of the Ageing and Disability Commissioner. What is unclear to us is what process would be followed in the event that a support agency acts in a way that is contradictory to the directions of the authorisation panel, and whether the Ageing and Disability Commissioner will receive reports of such instances, as we think should be the case.

Q10: Do you have any other comments on the Bill?

We cannot support Cl. 11 in its current form

We are concerned that there is a gap in the mechanism for managing emergency situations where an individual cannot consent themselves, there is no authorisation by an NDIS authorisation panel, and an appropriate person cannot be found to consent on their behalf (as anticipated under Cl. 11 of the Bill).

We interpret this as meaning that in emergency situations, a NDIS provider could apply restrictive practices to an individual without their consent, without external scrutiny, and that the requirement to obtain consent is only triggered if there is a belief that using restrictive practices will continue to be necessary. We understand that the NDIS provider would not be legislatively required to obtain consent for such activities for up to 20 days.

The issue is, what constitutes an emergency, or harm are subjective. These terms are not defined in the Bill specifically and we know that providers which use restrictive practices will always argue that their use is appropriate in the circumstances. It is very concerning to consider that a person with disability may be subject to restrictive practices they do not consent to for up to 20 days without any monitoring.

This is not an acceptable situation and we would not support such a process.

PDCN proposes that a more rights-centred approach would be for service providers to seek interim consent via an appropriate Government Authority within a period of no more than 48 hours for each instance of restrictive practice while at the same time remaining obligated to make all efforts to seek consent as prescribed under Cls 12 and 13.

The Ageing and Disability Commissioner would not be the appropriate person to provide consent, given the Commission's administrative and review functions. A logical choice that is immediately apparent to us would be NCAT's Guardianship Division.

Advantages of using the Guardianship Division in emergency situations where restrictive practices might need to be utilised would be that a decision would be made by professional trained experts, accustomed to assuming responsibility for decisions around individuals' health and welfare. Any consents should be for the minimum period necessary.