Submission to the Department of Communities and Justice on Restrictive Practices Legislative Framework

March 2025

> ***" One story about the restraint or seclusion of a child with a disability is one story too many."***
>
> ***Behind Closed Doors Restraint and Seclusion report, Manitoba 2019***

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Acknowledgement:

Family Advocacy would like to acknowledge the traditional custodians of the lands on which this report has been written, reviewed and produced, whose cultures and customs have nurtured and continue to nurture this land since the Dreamtime. We pay our respects to their Elders past, present and future. This is, was and always will be Aboriginal land.

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Introduction

Family Advocacy is a not for profit disability advocacy organisation that works across New South Wales (NSW) to advance and protect the rights and interests of people with developmental disability to live a meaningful inclusive life and have access to the same opportunities as the majority of Australians. This means being included in education, employment, and community with the right to live safely, with dignity, and free from violence, abuse, neglect or exploitation.

We were founded 33 years ago by families whom work with, for, and on behalf of, people with disability. We continue to be governed by families and provide support in the following ways:

- Advocacy advice and advocacy information to individuals
- Advocacy development for family members of a person with disability
- Systemic Advocacy

We appreciate the opportunity to be able to provide input on behalf of people with disability and their families for this Consultation discussion paper on Restrictive Practices Legal Framework in NSW.

Our comments and recommendations are premised on more than three decades of working with families who experience inequities and failures in the education system in New South Wales. Family Advocacy has been a part of the many reviews, roundtables, working groups and inquiries about students with disability over decades. In addition, Family Advocacy is on the steering committee of the Australian Coalition on Inclusive Education.

Due to the breadth and depth of our experience in the education area at the individual advocacy and systemic levels, we believe we are in a good position to provide valuable feedback to the Department of Communities and Justice (DCJ) and accordingly, would welcome the opportunity to discuss the points we raise, or appear at any hearings.

Overview

At the outset, we endorse the submissions of People with Disability Australia PWDA and Council for Intellectual Disability CID and as such do not wish to repeat the same concerns but do wish to add some further points.

In summary, we agree with their viewpoints that the Consultation Paper is not asking the right questions in the first place, that it is too narrow and prescriptive in scope, fundamental human rights are involved, the suggested features of an optimal decision making system, highlights the need for supported decision making, the dangers of appointing a Senior Practitioner when we have a consent based system for the last 30 years, weaknesses and tensions in the current guardianship system, how the current guardianship system should be reformed, safeguards needed if a Senior Practitioner authorisation system is pursued particularly independence, any new legislation should seek to minimise the use of restrictive practices in the range of service systems, not just NDIS services. We agree the Ageing and Disability Commission should have cross sectoral roles in monitoring and promoting good practice in behaviour support and use of restrictive practices.

We particularly agree the “most fundamental recommendation is for government to bring together a working group with representatives from the disability advocacy, positive behaviour support and mental health sectors to consider the results of the current consultation and provide advice on the best legislative model for decision making about restrictive practices. With our particular expertise in the early education and education space, Family Advocacy would be interested in being a part of this working group.

Restrictive practices constitute a breach of human rights under a number of United Nations conventions relating to torture, the rights of the child, and the rights of persons with disabilities, to which our Government is a signatory. We are pleased with the intention of the framework to reduce and eliminate use of restrictive practices. However, it comes with a caution that such aspirations have been asserted by government as well as independent bodies for the longest time, but to no avail. We cannot stress strongly enough, that if the government is serious about elimination, it needs to do something different to the past. It also needs to invest in service reform and all settings whereby restrictive practices are currently occurring. This does not have to be an expensive investment but more an intentional effort. If a bad cook gets new cooking utensils it will not change the quality of the meal. To this point if stronger reporting processes are developed it will not lend itself to the reduction and elimination of the restrictive practices within a setting. What will work to this end however is changes within the actual settings starting with mindsets, knowledge through to the responses that follow.

Family Advocacy have been very passionate about shifting perceptions around restrictive practices for decades. For too long, restrictive practices have been seen as a practice that is acceptable. In reality, it is a legally sanctioned form of violence which in any other setting would be considered a crime. It is important to recognise for a more valued group in society (for example, the healthy and wealthy), this approach would be unacceptable to others in society. The reason why this is considered acceptable is because our society devalues people with disability, whether this is conscious or not. People with disability's vulnerability is compounded by this devaluation, which plays out within the systems created to support them. It is time to ensure these systems promote non-violence to have a flow on effect on how an individual supports a person with disability.

In this paper, we are providing commentary and recommendations in relation to the regulation of restrictive practices with NDIS service providers, but we are also concerned about all settings in which it occurs. One setting of particular concern, given the majority of our enquiries are education related, is the use of restraints and seclusion on children with disability in schools. However, our concern reaches across all settings in which this practice is currently occurring.

Once violence is permitted, it's a slippery slope and creates a power imbalance, the person with disability vulnerable to the attitude/perceptions/values of the service provider. This is supported by recent research and evidence before the Disability Royal Commission has demonstrated that, in practice, restraint and seclusion are used in school settings for a variety of purposes beyond or in addition to a protective purpose, including as a means of coercion, discipline, convenience or retaliation, and to prevent damage to property. The use of restraint or seclusion for non-protective purposes is inconsistent with human rights norms.

It is critical for service providers to go beyond the current culture of crisis management and risk prevention. A big step forward will be adopting prevention and early intervention measures, discussed throughout this submission.

Prevent strategies

Preventing unauthorised restrictive practices (or abuse of any kind) means having clear policies and guidelines in place that are built on human rights and practices which maximise the empowerment of people with disability and person-centred approaches.

Prevention is also about creating the right organisational cultures; ensuring staff have the right values, experience, attitudes, supervision and training. It's about clear and transparent processes where feedback is sought, people can speak up without recrimination and there is a prompt response.

We share some valid points for prevention strategies from Anne Greer, a well-respected behaviour support practitioner working with people with complex disabilities over decades. For those supporting a person with disability, apart from having a belief that a person with disability is a person to be valued, it would assist for them to be taught a suite of strategies to use to support people with disabilities. For example:

- **Questioning what is the person trying to tell me?** Not how do I stop this behaviour.
- **How do we know when these behaviours are starting to build** and can you adjust your expectations with what is happening today, your tone of voice? Then the moment you feel a person is on edge, you recognise that and change the things you might do and how you do them.
- **Understanding the role of boredom**. A person with disability does not have socially valued roles, and doesn't have real things to do other than "time-wasting" activities such as going to group bowling as

that is what is scheduled for the Day Program that day. As a result, they generally have a low skill level and when skills are low is when behaviour can tend to happen.

- What are the good things in life for this person? Working on a meaningful life, getting plugged into the community is a critical part of the strategy.
- **Motor movement differences** – start, stop, transition, sequencing. Transitions seem to be the most problematic time for behaviour, usually mostly anxious, so we need to help a person understand what is happening now and what is happening next.
- **Share power and control** – if a person feels they have more control over their life, their behaviour will reduce. We need to stop saying 'no' all the time. The more we say "yes" the more a person is topped up and thus the more tolerant they would become when the word "no" is said to them.
- We should be taking the time to **consider what are the conditions around that person that might be creating the reaction or "learned response"** from the person with disability, and what can we do to change this learned response.

We also note people with disability said that they feel safe when service providers[1]:

- **listen**
- **respect** people's choices and decisions
- **involve people with disability** in planning their services
- make sure that **staff can do their job properly**
- get to know people **and treat them as an individual**
- support **contact with services** like police or advocacy
- ensure **respect for personal space and privacy**
- offer **choice about who people live with**

Whilst all of the above sound like common sense, unfortunately they are not common practice. Whilst we note the National Disability Services has a national initiative, Zero Tolerance, to build the capacity of service providers, the fact that restrictive practices have not been reduced or eliminated suggests that not enough is being done to educate service providers into this mindset, coach staff, provide feedback, and model good reflective practice. Or perhaps what is being done is not the correct approach and getting to the hearts and minds of the sector. Our point here is we are not there yet in relation to a satisfactory approach that works towards our joint objective of reduction and elimination.

There is a danger the law remains largely theoretical than truly transformative

Over the years, academics have suggested we need to develop legislation, policies or a framework towards the reduction and elimination of restrictive practices, which is what this Consultation Paper is addressing. Whilst this can be seen as a helpful step, on its own, is not the panacea and will most certainly not have the effect of reducing restrictive practices. Proof of this, and deeply concerning to us, is the recent reporting requirements through the NDIS which have revealed an astronomical rise in unauthorised restrictive practices. For Jan-Mar 2023, 439,322 URPs were reported, up by 33% from the same reporting period the year before[2]. As we have asserted, it's a slippery slope. There is a strong relationship between the use of restrictive practice and other forms of violence, neglect and abuse against people with disability which undermines the ability of people with disability and support workers to

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[1] National Disability Service initiative, *Zero Tolerance*, 'Speaking Up About Safety" report 2014 (updated 2016)

[2] NDIS Activity Report: 1 January to 31 March 2023

recognise violence and respond to it as a crime.

Address devaluation as the root of the problem

As long as certain groups of people are devalued, and then segregated and congregated, and are pushed into devalued roles of “menace” or “burden”, then human services in today’s environment will continue to use various forms of restraint, no matter what policies and processes are in place. This may be evidence of the systems trying to bureaucratically ‘manage' a deeply rooted and historical pattern of structural violence in services against the vulnerable, but looking at the wrong source or level. Devaluation is the obvious problem that people avoid discussing or acknowledging. This needs to change. We need to look to ways to curb social devaluation.

Need to focus on organisations and how they are structured, staffed and what culture is embedded rather than being just behaviour focused

The proposed Restrictive Practices legislative framework focuses on the person (what is their behaviour) and that may risk putting all the onus on the person being restrained without recognising organisational and system factors. Alongside this, it is essential that organisations consider how they structured, staffed and what culture is currently embedded in it. This becomes an essential component of the change as for the service to truly meet the needs of the person and particularly concerning behaviour, the supports and structures need to provide an informed and flexible approach.

Empirical frameworks such as Social Role Valorization (SRV) can assist greatly with matters such as culture and practice and we have seen first-hand many examples of success in its application to assist in the elimination of restrictive practice. A strength of this framework is that it also concerned with the previous wounding (trauma) experienced by the person and this identification becomes a key component in supporting elimination of such behaviours. This framework also assist staff to understand their own devaluation towards people with disability and as such forms a consciousness around behaviours of staff and organisations in their responses to people with disability. Family Advocacy is happy to discuss this further with DCJ how this training can be assessed.

Culture of belonging, respect and acceptance is a vital preventative factor

To elaborate further on the importance of culture and in reference to school settings, as a prevention factor, our families share that their child’s behaviours of concern will dissipate where there is a culture of good rapport between the teacher and student, as this creates a sense of belonging, the student feels valued, understood, respected, and heard (even if they are non-verbal).

Teachers must navigate a range of unique needs, including diverse behaviours, communication styles, sensory sensitivities and styles, and self-regulation difficulties. A significant challenge is fostering positive peer interactions, as some students' behaviours may inadvertently dysregulate others. Establishing a safe, structured, and supportive environment is essential to promoting meaningful connections. Understanding each student's individual needs and implementing tailored strategies help create a classroom dynamic that fosters engagement, collaboration, and emotional well-being. Understanding the unique needs of children with severe intellectual disabilities, a teacher fosters trust through consistent communication, patience, and personalised teaching strategies.

One teacher shared: “Drawing from my experience, one of the most effective strategies for building rapport with students early in the school year is establishing clear routines and expectations from the outset.

Setting consistent learning expectations, daily classroom routines, and structured transitions around the school helps students feel secure and confident in their environment. Predictability reduces anxiety, fosters independence, and supports self-regulation. When students know what to expect each day, they are more likely to engage positively with their peers and teachers, creating a foundation for strong relationships and a productive learning environment.

In my setting, student feedback takes various forms, particularly as many students have complex communication needs and may struggle to articulate their thoughts verbally. To ensure student voices are heard, we use alternative strategies to interpret their needs and experiences. Observing behaviours, engagement levels, and emotional responses provides valuable insight into how students are feeling and interacting within the learning environment. By carefully assessing these cues, we can refine our rapport-building approaches, adjust support strategies, and create a more inclusive and responsive classroom that fosters trust, comfort, and meaningful connections.

Fostering a culture of mutual respect in a school requires a whole-school approach, where collaboration between teachers, leadership, therapists, and support staff is essential. Establishing clear, consistent expectations and individualised support strategies ensures students feel valued, understood, and respected. Staff must model respectful communication, actively listen to students' needs—whether verbal or through behaviour—and create a safe, predictable learning environment. By integrating student-centred approaches, social-emotional learning, and inclusive practices, schools can cultivate an environment where students and staff develop trust, respect, and meaningful connections, enhancing both educational outcomes and personal development."

We would strongly encourage DCJ to find a way to incorporate these preventative factors discussed. For example, mandatory school personnel receive training in disability competency in a similar way as cultural competency education, which could include topics such as forming right relationships (knowing the child), understanding behaviour as a form of communication, trauma informed practices, restrictive practices and the harm they do, ableism and unconscious bias. If a student feels safe, understood and valued, then they can learn. Where there are times when a student becomes unregulated, there is now much research to empower a teacher on how to support the student to de-escalate a situation by getting to know the child, being understanding and making reasonable adjustments.

We also note the NSW education system has a written a Restrictive Practices Reduction and Elimination Policy which was supposed be in force in 2024 but was then delayed to Term 1, 2025 in order to allow time for schools to understand it. As from the writing of this submission, halfway through Term 1, 2025, it is still not in force with no indication of when it will commence.

Need to correct the power imbalance

As far as we understand it, when a complaint is made by a participant, the Commission calls the provider and believe what they say without proper, robust, balanced investigation. The person with disability and their families are then devastated and lose all confidence in the complaints process. In the education system, the Disability Royal Commission and the 2024 NSW Education Inquiry highlighted the flaws in the complaints system whereby the Department of Education polices itself and recommended the need for an independent complaints system. The lack of procedural fairness in unfair to the child and their families, who often do not hear about the restrictive practice occurring and only figure out something has happened by observing bruises on their non-verbal child or expressing extreme stress. It is wrong to place the burden on the person with disability or their family member, to do all the heavy lifting. We must also bear in mind there are many people with disability who are extremely vulnerable and often, have no voice at all. The system should be proactive in stamping out poor practices, individually and systemically, to correct the power imbalance.

Conflict of interest

We are extremely concerned that a whole new industry will emerge with organisations profiteering from the authorisation process. Certainly, the economic motivation (making money through restraint training) is significant. We have witnessed in other jurisdictions such as the U.S, so many companies sell their training packages, and make their efforts sounds like restraint reduction, but they have a compelling motive to want to see restraint continue so they can earn profits.

International examples successfully reducing restrictive practices

Whilst there are more international examples to explore, the results of these 2 projects are significant and worthy of further exploration as to what are the factors of success, by DCJ.

Massachusets Department of Mental Health Restraint/Seclusion Reduction Initiative (RSRI)

In November 2000, Massachusets Department of Mental Health Restraint/Seclusion Reduction Initiative (RSRI) through its Licensing and Child/Adolescent Services Divisions, embarked on a mission to reduce and ultimately eliminate the use of restraint and seclusion in all child and adolescent inpatient and intensive residential treatment facilities in the state**.** . This work is ongoing. **Between November 2000 and January 2005, episodes of restraint and seclusion (per 1,000 patient days) decreased 84.4%, 80.4% and 78.7%, respectively, in child (ages 5-12), adolescent and mixed child/adolescent units.**

Interagency Restraint and Seclusion Prevention Initiative

In response to growing concern about restraint and seclusion use in child-serving settings, the Commonwealth has organized a cross-secretariat effort to reduce and prevent their use. The Initiative brings together leaders from the state Departments of Children and Families (DCF), Mental Health (DMH), Youth Services (DYS), Early Education and Care (EEC), Elementary and Secondary Education (ESE) to work in partnership with the Office of the Child Advocate and parents, youth, providers, schools and community advocates to focus on preventing and reducing the use of behaviour restrictions that can be re-traumatizing.

The vision for the multi-year effort is that all youth-serving educational and treatment settings will use trauma informed, positive behaviour support practices that respectfully engage families and youth. This initiative capitalizes on the Department of Mental Health's award-winning, nationally recognized, 10-year restraint and seclusion prevention effort that has occurred state-wide across all psychiatric facilities and produced significant results, making DMH's work a national model of innovation in reducing and preventing seclusion and restraint.

The Pennsylvania State Hospital System[3]

The Pennsylvania State Hospital System's use of containment procedures has been studied for >30 years. This prospective study assessed the effects of ending the use of seclusion and mechanical restraint in the system's six civil hospitals and two forensic centers from 2011 to 2020. The study examined the effect of this change on key safety measures: physical restraint, assaults, aggression, and self-injurious behavior. In total, 68,153 incidents, including 9,518 episodes of physical restraint involving 1,811 individuals, were entered into a database along with patients' demographic and diagnostic information. All data were calculated per 1,000 days to control for census changes. During the study, mechanical restraint was used 128 times and seclusion four times. Physical restraint use decreased from a high of 2.62 uses per 1,000 days in 2013 to 2.02 in 2020. **The average length of time a person was held in physical restraint was reduced by 64%,** from 6.6 minutes in 2011 to 2.4 minutes in 2020 ($p<0.001$). All safety measures improved or were unchanged. Use of unscheduled medication did not change. **The hospital system safely ended the use of mechanical restraint and seclusion by using a recovery approach and by following the six core strategies for seclusion and restraint reduction.**

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[3] G. Smith and anors, *Effects of Ending the Use of Seclusion and Mechanical Restraint in the Pennsylvania State Hospital System*, 2011–2020

Response to Consultation Paper Questions and Proposals

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

Yes.

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

Yes, it should cover all NSW settings in which people with disability are subject to restrictive practices. This includes all education settings such as pre-schools, early education and care centres, public/independent/Catholic schools and tertiary institutions.

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).

Agreed but expanded, see Question 4.

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.

Agreed.

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?

Obviously, this will cause confusion, uncertainty and duplication, especially for people with disability who receive NDIS services and live in aged care, and for providers who operate in both sectors. So in this respect we support in principle one system however the settings have to be right otherwise we run the risk of trapping people into one way of doing.

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)?

Agree, but should apply to all people subject to restrictive practices. DRC Recommendation 6.35 (b) is sound but not complete. With consideration to the National Framework, we recommend the principles take a more holisitc approach:

In no particular order;

- **Reduction and elimination of restrictive practice** - as the overarching principle underpinned by the following principles below:
- Place a “duty to prevent” restrictive practices on the service provider
- Must be complemented with good practices known to prevent and reduce restrictive practices
- Promote socially valued roles, personal social integration and valued social particiaption for the person with disability
- Recognise and improve organisational and system factors that risk putting the onus on the person being restrained rather than simply placing sole focus on the person (their behaviour). The onus should be on the supporters and what they may have missed about knowing and supporting the person.

- Roll out training that gets to the heart of the issue and considers in combination the wounding or trauma of the person. Training such as Social Role Valorization.
- Adopt evaluative tools such as the "Model coherency tool" to assess organisations currently using restraints
- Human rights focused - should only occur in very limited and specific circumstances, as a last resort
- Person-centred - Self-determination over their lives and an individualised approach
- Supported decision making built-in to support the person's will and preferences
- Least restrictive
- For the shortest time
- Consistent approach across all settings
- Accountability and transparency through documentation, benchmarking and evaluation
- Monitored
- Reviewed regularly
- Raise awareness, provide education and accessible information about restrictive practices - for the person with disability, their guardian or advocate, service provider and their staff.
- Properly resourced

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

See Question 4. Also, ensure all relevant international human rights instruments be considered including but not limited to the Convention on the Rights of Persons with Disabilities (CRPD), Convention on the Rights of the Child, Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment (and the Optional Protocol), and United Nations Declaration on the Rights of Indigenous peoples.

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

Yes. We agree with those mentioned in the DRC "Recommendation 6.36 Immediate action to provide that certain restrictive practices must not be used". Given our area of expertise is in early education and schools, we wish to reiterate those prohibited practices mentioned in educational settings. We find it extremely disturbing that this list needs to be explicitly provided, but clearly evidence from the DRC has revealed these practices are being performed on children and young people. See extract below, recommending States and territory governments should immediately:

"Provide that the following are not permitted in education settings:

◦ **the use of restrictive practices:**

• as a form of discipline, punishment or threat, as a means of coercion or retaliation, in response to property destruction, for reasons of convenience;

◦ **life threatening physical restraints**, including physical restraints that restrict a student's breathing or harm the student by:

• covering the student's mouth or nose, or in any way restricting breathing, taking the student to the ground into the prone or supine position, causing hyperextension or hyperflexion, of joints, applying pressure to the neck, back, chest or joints, deliberately applying pain to gain compliance, causing the student to fall, having a person sit or kneel on the student;

◦ **chemical restraints**

◦ **mechanical restraints**

◦ **clinical holding:**

• as a behaviour support strategy, to enforce the compliance of a student in undertaking personal care that is non-urgent and does not present a risk to the student, to punish a student

◦ **denial of key needs, such as food and water.**

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

Agreed

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

Agreed

Question 7: Do you agree that:

- the framework should use the NDIS definitions of restrictive practices?
- No. The definition of restrictive practice should be expanded beyond the NDIS definition.[4] Family Advocacy acknowledge the need for consistency in definitions across settings and jurisdictions and as such, recommend the expanded definition suggested below also be adopted in the NDIS definition. The examples provided are based on anecdotal evidence provided by our families in educational settings or reported in the media.
- ***seclusion***, such as the sole confinement of a student at any time in any room where the doors and windows cannot be opened by that person, or they are placed inside a cupboard, or fenced in an area with the gate locked, sometimes euphamistically referred to as a ‘time out” to soften the fact that it is seclusion.

> *Use of sole confinement and time out placing my son away from their peers and natural supports and safeguards.*

> *A child with autism was restrained by teachers and locked in a time-out room for more than an hour, and despite instructions that he was to be checked on after 3 minutes, a teacher standing outside the room ignored him, during which time he wrapped an electrical cord around his neck.*

> *I dropped into the special school and saw my child in his wheelchair facing a wall instead of the playground in a line with other students in wheelchairs also facing the wall. I decided right away that that was his last day in the school and we moved to the local regular class, much better.*

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[4] This expanded definition is a combination of what was suggested in the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (the “National Framework” 2014) and the JFA Purple Orange report “Minimising and Eliminating Restrictive Practices: A Consultation for the ACT Government: Final Report” (2017).

Sent to 'planning room' for misbehaviour for specified periods of time - mostly gets into further trouble as inadequate supervision and he leaves. He's told he should not leave until teacher gives permission - mostly occurs during recess or lunchtime

- ***chemical restraint***, such as medications that blunt the person's emotions, cognition, and motor activity. For example, schools that refuse to allow a child access to school unless they take a certain medication.

After an incident occurred where my son "lashed out", I was told my son could not come back to school unless he took medication to calm him down. What they failed to tell me, and I subsequently found out, was that he was surrounded by four boys and he was being bullied. If the school had addressed the bullying, the behaviour would have stopped. Instead, my son was in fear of his life and he retaliated to protect himself. When I picked him up, he was laying on the floor in the foetal position, clearly distressed and traumatised

- ***physical restraint***, such as holding or 'pinning down' a student by another person/s.

My son came home from school very distressed. Once I finally managed to calm him down he told me he had been pinned to the ground in a prone position by multiple staff members at school. I was not informed that a restrictive practice had taken place. He did not have a behaviour support plan in place at the school. This is not acceptable. He has been traumatised ever since.

My son came home upset after school one day and told me the learning support teacher dragged him by the leg whilst hiding under a table. The school did not report this incident to me. Apparently, he wanted access to the computers and was not allowed to. Rather than give him some space and time to accept this, he was boxed into a corner by the teacher which felt threatening so he hid under a table. Again, rather than keeping calm and giving space to allow for reasoning and self-regulation, the teacher chose an antagonising approach which only made things worse. My son was grabbed by the leg and dragged along the floor. My son is a teenager. He felt ashamed and still does when in this teacher's company.

- ***mechanical restraint***, such as devices that limit a person's movements (and this includes the removal and/ or disengagement of mechanical supports that assist the person's movements). For example, tying a child down to a seat with a belt.

My son was not allowed to use his motorised wheelchair at recess in the name of "safety". The staff member turned the power off to the chair and he was stuck in the classroom the whole of recess and left without any way of moving.

- ***environmental restraints***, are very wide ranging such as preventing free access to all parts of a person’s environment or house, locking the refrigerators, restricted access to knives, the front door being locked to restrict access to the community.

- ***social restraint***, such as the imposition of sanctions that restrict the person’s access to relationships/opportunities they value. For example, not allowing a family member/friend to come over and take them out of their group accommodation to go on an outing.

My child’s friends had spent all of the primary school years finding innovative ways to include and play with him in his wheelchair in the playground, including earning wheelchair licences to be able to wheel him around and play handball at recess and lunch. Once he started Year 7, my child was placed in his wheelchair in the out of bounds area of the school with a two teacher’s aide at the top of the hill, whilst the Year 7 play area was at the bottom of the hill, so away from his peers/ friends. His friends told me this, the school did not even consider changing this. I think it suited them but they used the excuse it was in the name of safety. Apart from it being lonely, and distressing, it meant social death for him in high school. No kid wants to hang out with him when there is an adult velcroed to him. All our social capital gained in primary disappeared.

- ***psycho-social***, such as power control strategies which might include threats, intimidation, fear, coercion, discipline, or retaliation.

In Kindergarten, he had the most amazing teacher that understood different learning styles, really got to know him and my son would run out of class with a smile on his face. The next term he got a new teacher who was the polar opposite, rule oriented without flexibility and with a punitive approach. One day, he would not come out of class and I found him under the table, screaming. The next morning, he got himself ready early saying he wanted to go to the bin. Turns out, the teacher had chastised him for not sitting still for one hour, ripped his sticker book rewards chart and told him he would have no friends if he kept behaving that way. I say again, this is in Kindergarten.

- ***organisational restraint***, such as excluding the person from activities, and restrictions to the person's choice. For example, not allowing a child to attend excursions/incursions such as school camp, school carnivals

My child was specifically asked not to attend the swimming carnival, athletics carnival, excursions, incursions or school camp. No inclusion happening at all. I believe this was the school’s way to get us to leave. Often, permission notes would ‘accidentally’ not come home.

In Year 10, all the students were to attend a tax seminar but the room it was scheduled in was upstairs so my son could not attend. Essentially, he was locked out of the room as he could not access the top floor. This was his fourth year in the school and this basic consideration was overlooked.

- ***communication restraint,*** such as switching off someone’s communication device when this is their primary form of communication

> *My child was never given support by someone that can communicate Auslan sign language with her, the language she can understand and respond to. The teacher's aide knew key word signing she had learned at a special school, this is very different to Auslan and my child could not communicate in this language. It's like having a Spanish speaking teacher when you speak English. Also, my child had an FM system, which is a microphone that would need to be attached to the teacher's lapel and feed into her hearing aide. This was sometimes used and sometimes not. The teacher was supposed to take it off during classwork time when she was going around to individuals but it would often be left on. This was very distracting and meant my child found it hard to concentrate to do classwork.*

- ***decision making restraint***, such as failing to provide options for supported decision making.
- ***consequence driven restraint***, usually involving the withdrawal of activities or items.
- the Senior Practitioner should have the power to issue guidelines that clarify how the definitions apply in different situations?
- Yes, but co-design is essential, with people with disability, their families and representative organisations who are well aware of the pitfalls.

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

- Should the Senior Practitioner have the power to prescribe additional and/or more detailed information for inclusion in the BSP? If so, what information?
- 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?
- Should there be any specific provisions relating to consultation in the development of a BSP, in addition to the requirements in the NDIS Rules?
- We propose a working party ought to consider these matters but we share a few thoughts here. We would also suggest turning to other jurisdictions such as the U.S and Canada to explore what it is that has helped in the prevention and reduction of what are termed here as behaviours of concern.
- There needs to be a safeguard on who is the independent behaviour support practitioner. There is enormous variation in the skills of behaviour practitioners and less conscientious providers may choose a practitioner who will not challenge them and thus there is a danger this becomes a tick box exercise. At present, the independent practitioner is allocated by the Department of Communities and Justice. In our opinion, the this role should sit in the Ageing and Disability Commission and along with adequate funding.

In terms of Behaviour Support Practitioners and any specific provisions relating to consultation in the development of a BSP, they would need to possess some or all of the following qualities:

- be independent
- hold the believe that reduction and elimination can and should occur across the different sectors
- believe in the role and expertise held by family
- recognise intersectionality and the double or triple disadvantage it poses on a person
- understand that this work requires practitioners to know the person with disability well
- extensive experience in eliminating the use of restrictive practice

- be vigilant about human rights and fundamental freedoms that should be enjoyed by all to live a life of inclusion, participation, self-determination and free from discrimination, abuse & neglect, including a working knowledge of policy and legislative requirements relating to restrictive practices.
- take a deeper look into the structures/environment/staff/ and responsiveness of the system surrounding the person with disability is also required
- appreciate the power imbalance for a person with disability being "done to" by a service

  One of our family members shared that a "cookie cutter approach would not work for his son as what works is highly individualised". See case study below.

> *"There is a significant imbalance of power experienced in all settings for person with disability receiving services and supports. Of course, I would like my son to have a say in his behaviour support plan that includes using restrictive practice but he has an acquired brain injury and cannot verbally communicate. So to the best of my ability and with my son's best interests at heart, I advocate for him. My son has a very particular passion for newspapers. If Derek carries a newspaper under his arm, it makes him feel stable and confident in the world.*
>
> *If he does not do this, the need would arise for restrictive practice, as his anxiety would rise and behaviours of concern would follow. Often, if given the chance, the person with disability themselves knows the solution as to what stabilises them. Rather than having a theoretical, broad brushed approach, really knowing the person and tapping into an individual's true desire, however unusual it may seem, is the key to reducing the need for restrictive practices."*
>
> Alan, father of Derek

This also raises the broader issue of providing awareness through education for those who are implementing the restrictive practice. In any setting, while the use of restrictive practice is intended to protect the person and others from harm, they also pose significant risks to the well-being of the perpetrator and the receiver of the restrictive practice, and violate fundamental human rights. In any setting, staff/personnel must navigate these complex ethical scenarios, often in very resource – and time – constrained circumstances, and attempt to strike a balance between competing values or rights. It is therefore critical that staff/personnel are helped to understand the negative impacts of devaluation of a person with disability, understand their role in projecting and reinforcing this devaluation, and be provided clear guidance about the traumatic impacts of the use of these practices and the human rights violations of their use.

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

We propose a working party ought to consider these matters but to share our current thoughts, there ought to be a duty of care placed on a BSP to prevent and/or reduce restrictive practices to raise the stakes to provide some potency around the seriousness of authorising a restrictive practice. The needs to be a belief that the person with disability and their support network should be actively involved in the decision-making process about things that affect their lives. Where relevant, a requirement for supported decision making to be woven into the process so the person with disability has the opportunity to express their will and preference to independent parties as this may provide valuable insights into what a person's behaviour is attempting to communicate.

Along with an individualist approach, collaboration is required with the BSP, the person, their support networks, and service providers to identify the best solutions possible.

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.

These matters should be considered by the working party that we propose.

Question 10: Should APOs be empowered to either:

- **authorise particular categories of restrictive practices without separate Senior Practitioner authorisation (a partially delegated model). If so, what categories of restrictive practices should be able to be authorised by APOs? Should these be prescribed by legislation, or through class or kind orders?**
- **provide preliminary approval of restrictive practices, with final authorisation provided in all cases by the Senior Practitioner (a two step model)? What would be the benefits and risks of the above models?**

NO. Due to the conflict of interest that exists between what is best for the person with disability and what may be in the best interests of the organisation, the service provider should be kept at “arms-length” in this process. If this does not occur there is significant risk that the process of approval will both minimise the opportunity to reduce or remove the use of restrictive practice and not seek alternative and adaptive practices within the service context.

This safeguard also acts as a means to mitigate the use of historical responses to supporting people with behaviours of concern which in many cases has not proven to be effective or in the best interests of the person. Moreover, many disability services and mainstream services currently work with deeply held negative assumptions about people with disability such as ‘runner’, ‘hitter’, ‘screamer’, ‘overeater’, ‘attention seeker’ etc etc. Addressing such behaviour with restrictive practices and in turn reinforcing their assumptions creating a strong feedback look that will not lend itself to the deeper change and shift required. Making the person with disability in a lot of instances the scape goat around responses and in doing so removing the need for services to look at the necessary reform required internally address the supporter shortfalls leading to the ongoing use of these practices.

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

We propose a working party ought to consider these matters. Although we do refer to our discussion regarding the need for a holistic approach whereby the focus is not just about the person’s behaviour but looking more broadly to the organisations and systems and the changes required to allow the person to access the good things of life.

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?

See answer to Question 10. APOs would have unmanageable conflicts of interest.

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

These matters should be considered by the working party that we propose.

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.

These matters should be considered by the working party that we propose.

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 Agreed (at least if a senior practitioner authorisation model is adopted)

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

We propose a working party ought to consider these matters.

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

We propose a working party ought to consider these matters. In the case where a Senior Practitioner model is adopted , we would require the will and preferences of the person with disability to be considered.

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

We propose a working party ought to consider these matters.

Question 15: Should authorisation decisions:

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

These matters should be considered by the working party that we propose.

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?

We propose a working party ought to consider these matters

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

We propose a working party ought to consider these matters

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.

Agreed.

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.

Agreed.

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

Both.

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

Yes.

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

We propose a working party ought to consider these matters.

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?

We propose a working party ought to consider these matters.

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 propose a working party ought to consider these matters.

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

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

Agreed, however the danger here is that the focus on normalising restrictive practices rather than focussing on how to achieve good lives for people. As we have seen in the US, a whole new industry has been created and profited from doing this.

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

Yes.

Question 24: Should the Senior Practitioner have the power to impose sanctions for the misuse of restrictive practices, or are existing sanctions for misuse of restrictive practices sufficient? How should the interaction between sanctions provided for under NDIS legislation and the proposed framework be managed?

We propose a working party ought to consider these matters. However, in our opinion, whoever becomes the authoriser should have “teeth” such as broad investigative and other powers when it comes to holding unauthorised users of restrictive practices to account.

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?

We propose a working party ought to consider these matters.

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?

The Senior Practitioner should have functions of providing information and support to people with disability and their families to enable them to make empowered decisions about behaviour support including decisions about the use of restrictive practices. Beyond this, information should be shared about how a person with disability can access the good things of life, the importance of having socially valued roles, having a sense of purpose not doing time wasting activities.

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