

Office of the Public Advocate (Qld)
Systems Advocacy

**Submission to the National
Disability Insurance Scheme**

Proposal for a National Disability
Insurance Scheme Quality and
Safeguarding Framework
- Restrictive Practices

April 2015

Introduction

The Public Advocate (Qld)

The Public Advocate was established by the *Guardianship and Administration Act 2000* (Qld) to undertake systems advocacy on behalf of adults with impaired decision-making capacity in Queensland. The primary role of the Public Advocate is to promote and protect the rights, autonomy and participation of Queensland adults with impaired decision-making capacity (the adults) in all aspects of community life.

More specifically, the functions of the Public Advocate are:

- promoting and protecting the rights of adults with impaired capacity for a matter;
- promoting the protection of the adults from neglect, exploitation or abuse;
- encouraging the development of programs to help the adults reach the greatest practicable degree of autonomy;
- promoting the provision of services and facilities for the adults; and
- monitoring and reviewing the delivery of services and facilities to the adults.¹

In 2015, the Office of the Public Advocate estimates that there are approximately 115,745 Queensland adults with impaired decision-making capacity (or 1 in 32 adults).² The primary factors that can impact decision-making capacity include (but are not limited to) intellectual disability, acquired brain injuries arising from catastrophic accidents, mental illness, ageing conditions such as dementia, and conditions associated with problematic alcohol and drug use.

It is important to note that not all people with these conditions will have impaired decision-making capacity, and that impaired decision-making capacity does not necessarily impact all areas of an adult's life, and may fluctuate in response to situational issues. It is likely, however, that many people with intellectual, cognitive or psychiatric disability (hereafter referred to as cognitive impairment) may, at some point in their lives if not on a regular and ongoing basis, experience impaired decision-making capacity in respect of a matter.

An analysis of the available information on NDIS participants from quarterly reports indicates that in 2015, there were 5,004 NDIS participants who may have some form of cognitive impairment. This correlates to 66% of all participants (excluding the South Australian trial site).³

Of this group, 41% had a primary disability type of Autism and related disorders, 39% intellectual, 17% "other neurological", 10% developmental delay, 9% Cerebral Palsy, 8% Down Syndrome, 8% "other intellectual/learning", 8% Schizophrenia, 7% "other psychiatric", and 6% global developmental delay. The bulk of these participants were in NSW and Victoria as these trial sites had the broadest intake criteria.⁴

Interest of the Public Advocate

The Public Advocate has a strong interest in the issue of quality and safeguarding. Through both family experience and having worked with people with disability for over 20 years in roles spanning from front-line service delivery to her current position as Public Advocate in Queensland, she has seen both the positive and negative elements of support for people with disability first-hand.

¹ *Guardianship and Administration Act 2000* (Qld) s 209.

² Office of the Public Advocate, 'The Potential Population for Systems Advocacy' (Fact Sheet, Office of the Public Advocate (Queensland), April 2015).

³ National Disability Insurance Agency, 'Quarterly Report to COAG Disability Reform Council' (Report, 31 December 2014)

<http://www.ndis.gov.au/sites/default/files/documents/Report_to_the_Disability_Reform_Council_2014-15_Q2_Q2.pdf>.

⁴ Ibid.

As a result of both her personal and professional experiences, and the broad range of issues that she has encountered and sought to address at both individual and systemic levels, the Public Advocate is concerned to ensure that the forthcoming transformational change to the disability services sector (through the implementation of the National Disability Insurance Scheme (NDIS)) is undertaken in a way that both enables and empowers people with disability while still ensuring that there are sufficient safeguards to respond to and address issues should they arise.

The issue of restrictive practices is particularly relevant to the following functions of the Public Advocate:

- promoting and protecting the rights of adults with impaired capacity for a matter; and
- promoting the protection of the adults from neglect, exploitation or abuse.

In addition to this submission, which is specific to the issue of restrictive practices, the Public Advocate is also tabling a submission commenting on the broader range of issues articulated in the Consultation Paper that presents the Proposal for a NDIS Quality and Safeguarding framework.

Promoting and protecting the rights of adults with impaired capacity

The use of practices such as detention, seclusion, physical, chemical and mechanical restraint, and restricting access to objects impacts significantly on a person's rights to personal liberty and security, both of which are important common law and human rights.

From a human rights perspective, liberty and security are enunciated as the right to 'life, liberty and security' in article three of the *Universal Declaration of Human Rights* (UDHR)⁵. They are similarly articulated as civil and political rights in article nine of the *International Covenant on Civil and Political Rights* (ICCPR),⁶ which states that 'everyone has the right to liberty and security of the person'.

In this sense they do not protect an absolute right to personal liberty, but rather impose a prohibition on arbitrary arrest and detention and deprivation of a person's liberty other than in accordance with procedures established by law. Arbitrary detention according to the ICCPR Committee includes 'elements of inappropriateness, injustice, lack of predictability and due process of the law.'⁷ The protection of liberty, it is acknowledged by the ICCPR Committee, is not confined to imprisonment or police custody, but includes a wide range of circumstances in which a person may be deprived of their liberty, including involuntary hospitalisation.⁸

There is a similar emphasis in the common law where personal liberty is secured by the imposition of limits on the exercise of arrest and detention, unless authorised by law. Isaacs J in *Ex parte Walsh and Johnson; In re Yates*, acknowledged that although this principle cannot be found in any 'written constitution of Australia',⁹ the right to personal liberty forms part of our 'constitutional heritage and express fundamental principles and values which continue to influence the application and development of the common law.'¹⁰ Isaacs J summarised these principles as:

- I. Primarily every free man has an inherent individual right to his life, liberty, property and citizenship;
- II. His individual rights must always yield to the necessities of the general will of the State;
- III. The law of the land is the only mode by which the State can so declare its will.¹¹

⁵ Universal Declaration of Human Rights, GARE217A (III), UN GAOR, 3rd session, 183 plen mtg, UN Doc A/810 (10 December 1948).

⁶ International Covenant on Civil and Political Rights, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976).

⁷ Human Rights Committee, International Covenant on Civil and Political Rights, *General Comment No 35: Article 9: Liberty and Security of the Person* (107th session, Geneva, 11-28 March 2013) 4.

⁸ Human Rights Committee, International Covenant on Civil and Political Rights, *General Comment No 35: Article 9: Liberty and Security of the Person* (107th session, Geneva, 11-28 March 2013) 2.

⁹ *Ex parte Walsh and Johnson; In re Yates* 37 CLR 74, 79 (Isaacs J).

¹⁰ *Antunovic v Dawson* [2010] VSC 377, [25] (Bell J).

¹¹ *Ex parte Walsh and Johnson; In re Yates* 37 CLR 74, 79 (Isaacs J).

Effectively therefore, the underlying principle in our common law is that no one can be deprived of their liberty except in accordance with the law. The infringement of this principle is something that, as Brennan J said in *Re Bolton; Ex parte Beane* ‘the law of this country is very jealous of.’¹² Even the most ‘minor’ of infringements are viewed seriously.¹³

The use of restrictive practices, in particular the unregulated use of restrictive practices in Australia, has come to the attention of the United Nations Committee on the Rights of Persons with Disabilities, which made the following statement in its concluding observations on Australia’s initial report under the *Convention on the Rights of Persons With Disabilities* (UNCRPD):

‘The Committee is concerned that persons with disabilities, particularly those with intellectual impairment or psychosocial disability, are subjected to unregulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraint and seclusion, in environments including schools, mental health facilities and hospitals.’¹⁴

Promoting the protection of the adults from neglect, exploitation or abuse

There is a long history of using practices such as detention and restraint, including chemical restraint, in supporting people with disability in institutional care environments. These environments, despite ostensibly being health care facilities for the most part, were characterised by their custodial nature.

People with intellectual disability had few rights, were subject to containment under the authorisation of medical practitioners with no opportunities for review, and personal decisions about treatment, life style and education were made by the staff of the institution. They were under the complete control and direction of the institutional staff and government. Medical treatment could be carried out without consent.

When restrictive practices are used unlawfully, for convenience, or other than in accordance with a professional assessment and a positive behaviour support plan, they cannot be justified. In fact, it is difficult to see how the nature of their use might differ from neglect, assault and abuse of people with disability. Given the impact of restrictive practices on vulnerable people, ensuring their lawful use and establishing a clear safeguarding framework that requires transparency in their use is crucial.

In the case of *MJI*, the Queensland Civil and Administrative Tribunal described the environment of a 23 year old man with autism and intellectual disability for whom ‘containment’ had been approved as follows:

‘His physical environment is appalling. It is almost totally devoid of any furniture. It is poorly maintained, barren and lacks any personalised comforts or items. MJI generally receives his meals through a slot. He watches television by having the image projected on to a wall in one of his rooms. He has a relatively large yard area devoid of any equipment. This is totally enclosed via either a brick wall or fine wire mesh about 4 meters high. It has been described as a caged area.’¹⁵

In another case, a support worker described the conditions under which a client subject to ‘restrictive practices’ was living when she first met him in a residential disability service in Queensland:

‘She said that she was greeted by a support worker who unlocked and unbolted the front door. We were immediately inside a small room. This appeared to be for staff. This was double locked by another half door with Perspex leading to a small kitchenette. This was again separated by a wall which was half Perspex with another big locked door in the middle; beyond which was a small, bare, what appeared to be lounge area which had a chair bolted to the ground, a sleeping area, and unmade single bed with a couple of wall shelves above it, small drawers and a toilet. There were no doors to any of these areas. P was stood in the middle of this area. The worker proceeded to join the other worker at a small dining

¹² *Re Bolton; Ex parte Beane* (1987) 162 CLR 514 (523).

¹³ *Minister for Immigration & Multicultural Affairs v Al Masri* [2003] FCAFC 70 (Black CJ; Sundberg and Weinberg JJ) [88]

¹⁴ Committee on the Rights of Persons With Disabilities, *Concluding Observations on the Initial Report of Australia* (adopted by the Committee at its tenth session 2-13 September 2013) 5.

¹⁵ *MJI* [2010] QCAT 76.

*table, where they had obviously been sat watching P through this observation room. One of the staff unlocked the door to where P was standing, to let us in... they then locked it immediately behind us. There was handwriting all over those grey concrete walls... 'Help me, I want to die, I hate you.'*¹⁶

Such examples not only illustrate the impact of restrictive practices on people with disability but also the importance of ensuring that any regulatory scheme for authorising restrictive practices does not become an end in itself. Michael Kendrick emphasised the need to protect against regulation creating a one-way door where it is easier to get into highly restrictive settings than to get out of them, remarking that:

*'If we do not meet that test, then we have got a trap that just holds people frozen, which is what we had with the old residential institutions we largely replaced many years ago but are now recreating under the guise of 'needing' a new generation of restrictive practice settings. Consequently, we are now facing an unintended policy of the expansion of a new generation of horribly restrictive institutions both within communities and on the site of the old institutions that were discredited and devolved many years ago. Most certainly this is an ominous sign that we have not learned from the past and our safeguards against the abuses of that period are proving to be laughably weak if non-existent.'*¹⁷

¹⁶ Annette Osborne, Presentation at QAI Forum: Human Rights v Restrictive Practices (Friday 31 August 2013).

¹⁷ Michael J Kendrick, Presentation at the Restrictive Practices Forum (Queensland Advocacy Incorporated, Brisbane, August 23, 2010).

Position of the Public Advocate

The use of restrictive practices is a significant infringement on a person's human rights, in particular the right to liberty and security of the person and the right not to be subject to cruel, inhuman or degrading treatment or punishment. It is also potentially unlawful and may give rise to criminal or civil liability. It is therefore imperative that restrictive practices are only ever used as a last resort, that appropriate safeguards are applied and that there is appropriate monitoring and oversight of their use.

While not all people with disability exhibit behaviours that would result in them being subject to restrictive practices, those who do represent a significantly marginalised and vulnerable group of individuals. This is an important consideration in developing the framework that will serve to enable appropriate safeguards, particularly given that many individuals who have intellectual disability or cognitive impairment and who exhibit behaviours that are deemed to be 'challenging' from a service delivery perspective may also lack decision-making capacity and have limited natural supports.

Understanding behaviour: the person is not the problem

It is important to understand that 'challenging' behaviours are not a 'failure' of the person exhibiting them; they are a failure of the system around them. Similarly, it must be understood that 'challenging' behaviours are titled as such because they are challenging for the service provider or those supporting the person. In most instances, they are not challenging for those who exhibit them.

At its essence, behaviour is functional in nature; it serves a purpose.

For many people with disability, behaviour is a means of communication. It is their way of saying to those supporting them that they are in pain, or that they are upset. Or they may be saying that they are confused, anxious, sad or overwhelmed.

It could be any number of things that the person is trying to convey but if the people supporting them do not understand what makes the person 'tick' and/or have not learnt to speak their 'language', then ultimately the person's needs are not understood. Many of the people being supported by disability service providers have experienced years of not being understood. They are supported with people they do not like or they are forced into 'institutional-type' routines that do not fit their own lifestyle preferences.

For many people with disability who exhibit 'challenging' behaviours, their behaviours may have arisen from a single instance of not being understood. For some this may have originated when they were a child with a family who, despite trying their hardest, couldn't understand the 'language' that their child was speaking. For others, it may have started when they were at school, and then started generalising into other areas of their life. For many, almost contrary to belief, it begins when they start accessing specialist disability services.

Consider for example a person who tries to communicate to someone working with them that they want to be left alone only to find that the support staff doesn't do so.

The person may then try to push them away, or may turn their back to walk away themselves. But again, the support staff may persist in interacting with the person.

As with any of us, the person is likely to become increasingly agitated if they try in many and varied ways to be understood with no success. Ultimately, this escalation may lead to a person lashing out physically... and so the label of having 'challenging' behaviour is established.

If only the support staff had understood what the person was trying to tell them in the first instance; the future for such a person would be quite different.

Consistent with the paradigm shift that the United Nations *Convention on the Rights of Persons with Disabilities* has elicited with respect to understanding that disability results from the interaction between people with impairments and their surroundings as a result of attitudinal and environmental barriers,¹⁸ so too should we approach our understanding of ‘challenging’ behaviour. Behaviour must be understood within the context of the environmental factors that exist around the person.

For a person with an intellectual disability or cognitive impairment, as with any of us, it does not take long to ‘learn’ what works and what does not in terms of achieving the outcomes that they are seeking. It should not come as a surprise, therefore, when a person starts to increasingly rely on the ‘challenging’ behaviour as the first resort option in seeking to have their needs met. After all they have been ‘taught’ by others that this is what works. This scenario occurs every day in disability support services, it occurs every day in families. It is for this reason that the Public Advocate is concerned to ensure that any proposal involving restrictive practice use is appropriately contextualised by having a concomitant focus on positive behaviour support.

At its essence, positive behaviour support is about seeking to understand why a person engages in the behaviours of concern and, in doing so, how to avoid the ‘triggers’ that may prompt the person to engage in these behaviours. It is about acknowledging that the person is not the problem and seeking to ensure recognition for a person’s right to personal liberty and security through the provision of support that seeks to enhance not inhibit each person’s quality of life.

Principles of a framework for restrictive practices

The principles outlined below inform the Public Advocate’s response to the proposals for the regulation of restrictive practices outlined in the consultation paper: *Proposal for a National Disability Insurance Scheme Quality and Safeguarding Framework* (the Consultation Paper).

The Public Advocate believes that, as a minimum, any regulatory scheme for restrictive practices should:

- First and foremost be lawful;
- Be established within a framework that recognises the importance of ensuring that any proposal for restrictive practice use is premised upon a foundation of professional clinical input and assessment, and the development and implementation of a positive behaviour support plan;
- Require consultation with and input from the person, as well as from their guardians, family, friends and supporters in any proposal to use restrictive practices;
- Involve the application of appropriate criteria in providing approval for its use;
- Ensure that the granting of authority to use restrictive practices is situated independently from service providers proposing to use them;
- Incorporate appropriate safeguards;
- Involve independent oversight and monitoring; and
- Involve reporting, data collection and evaluation.

Lawful use of restrictive practices (principle 1)

The use of practices such as detention, seclusion, chemical, physical and mechanical restraint (other than when authorised, excused or justified by law) is unlawful for people with or without impaired capacity.

Outside of limited common law or statutory excuses or justifications (such as necessity, extraordinary emergency, or self-defence) which generally only permit the use of such practices in very limited

¹⁸ Convention on the Rights of Persons with Disabilities, opened for signature 30 March 2007 [2008] ATS 12 (entered into force 3 May 2008) (‘Convention on the Rights of Persons with Disabilities’).

circumstances akin to a serious emergency where there is a serious likelihood of harm,¹⁹ the use of practices such as detention and restraint can only be utilised if expressly authorised by statutory law, or a court or tribunal with appropriate authority.

The common law and statute law imposes limits on the use of unlawful detention and restraint. For example the use of detention may constitute the tort of false imprisonment,²⁰ or the criminal offence of deprivation of liberty.²¹ Any deprivation of a person's liberty could be a basis for the issue of the writ of Habeas Corpus.²²

These are remedies that are old but completely adaptable to modern day circumstances of involuntary placement and/or detention of people with disability in residential disability services and aged care services without appropriate authorisation.²³ The protection of a person's bodily security is protected in civil law by the tort of trespass, specifically battery,²⁴ and in criminal law by the offence of assault,²⁵ meaning that any bodily restraint of a person or medical treatment without their consent or other authorisation will be unlawful.

It is not sufficient to rely on common law excuses such as emergency or necessity for long term and ongoing use of restraint, detention and deprivation of liberty. Further any statutory authorisation of restrictive practices must be express and explicit. In *Coco v R*, the High Court discussed the common law principle that general words in a statute are insufficient to authorise interference with basic rights and immunities stating:

*The courts should not impute to the legislature an intention to interfere with fundamental rights. Such an intention must be clearly manifested by unmistakable and unambiguous language. General words will rarely be sufficient for that purpose if they do not specifically deal with the question because, in the context in which they appear, they will often be ambiguous on the aspect of interference with fundamental rights ((8) See *Chu Kheng Lim v. Minister for Immigration* (1992) 176 CLR 1 at 12 per Mason CJ).²⁶*

This means that the authorisation of restrictive practices requires explicit words in statute and cannot be read into legislative provisions, such as general guardianship legislation authorising substitute decision-makers to make decisions about accommodation, health care and services.

The use of restrictive practices in disability services (and other services including aged care residential services, hospitals, rehabilitation services and other health facilities) must have explicit statutory authorisation. Anything else imports a discriminatory approach into the law for people with disability where, unlike people without disability, their liberties and rights can be subject to infringements without proper authorisation.

Clinical input and assessment, and positive behaviour support (principle 2)

It is not sufficient to simply provide a regulatory framework to make lawful the use of practices such as detention and restraint. In Queensland, for example, the Carter report was adamant in its assertion that any legislative framework for restrictive practices should prohibit the use of such practices unless they are independently approved as part of an individualised positive behaviour support plan consequential upon a comprehensive assessment of the individual and his/her needs.²⁷ The aim of the positive behaviour support plan is to outline strategies to meet the adult's needs, improve the adult's capabilities and quality of life, and reduce or eliminate 'challenging' behaviours and thus the need for restrictive practices.

¹⁹ *R v Loughnan* [1981] Vic Rp 43.

²⁰ *Watson v Marshall* (1971) 124 CLR 621.

²¹ See for example *Criminal Code* (Qld) s355.

²² *Antunovic v Dawson* [2010] VSC 377.

²³ See for example *Antunovic v Dawson* [2010] VSC 377 where the writ of Habeas Corpus was issued in relation to a resident of a mental health service without statutory authorisation and *Skyllas v Retirement Care Australia (Preston) Pty Ltd* [2006] VSC 409 where the writ was issued in relation to a resident of an aged care residential service.

²⁴ *Colins v Wilcock* [1984] 1 WLR 1172.

²⁵ See for example *Criminal Code* (Qld) s335.

²⁶ *Coco v R* (1994) 179 CLR 427 [10] (Mason CJ; Brennan, Gaudron, McHugh JJ).

²⁷ William Carter QC, *Challenging Behaviour and Disability: A Targeted Response* (Report to Warren Pitt MP, Minister for Communities, 2006).

Further any legislative scheme for restrictive practices must be accompanied by:

- An ongoing and targeted investment in improving the disability sector's capability to implement a positive behaviour support approach; and
- Effective clinical leadership and oversight for assessment, planning, implementation and review.

There is also great merit in having a position such as a Senior Clinician or Practitioner who can provide appropriate clinical leadership, direction and oversight in a regulatory scheme for restrictive practices. Such a role could be placed in an independent oversight body (such as that described in principle 7) that has powers to direct service providers to cease certain practices, change behaviour support plans and initiate reviews of approvals to use restrictive practices.

Consultation with the person, and their guardians, family, friends and supporters (principle 3)

Consultation with, and input from, the person him/herself where possible, and with a person's guardian, close family and friends is not only an important safeguard, but is also more likely to provide for a robust response to the person's behaviours to the extent that people who are close to the person and know them well are usually far better placed to inform the development of, and/or changes to, any environmental and/or support arrangements that may be required.

The person and their guardian and/or close family or friends should also be involved in the assessment, the development of any positive behaviour support plan, and be able to give their views to inform the decision to authorise the practice. They should also play a key role in monitoring and validating the effectiveness of the plan's implementation, thereby also increasing the transparency associated with the use of restrictive practices over time.

However, not all people have close family and friends who are able to undertake an advocacy role in their lives. Vulnerable people with disability also need access to independent advocates who can ensure that they are aware of and can exercise their rights with or without support.

Appropriate decision-making criteria (principle 4)

Consistent with a rights-based approach (and so as to avoid arbitrary restrictions on a person's liberty), restrictive practices should only be applied to a person if appropriate criteria are met including that:

- There is a significant risk of serious harm to the person or to others if the practice is not utilised;
- The use of the practice protects the person or others from serious harm occurring;
- The decision to authorise use of the practice is capacity-based (in that it is only imposed if a person is proven to lack decision-making capacity in respect of consenting to the use of the practice);
- The use of the practice is only applied within the context of a positive behaviour support plan that has been designed to eliminate the need to use restrictive practices and improve the quality of the person's life, and that (at minimum):
 - is underpinned by an assessment by an appropriately qualified professional;
 - identifies trigger events, environmental factors and other situational issues that are likely to impact on the person's behaviour;
 - details the positive strategies that must be applied both in the provision of day-to-day support, as well as in response to signs of escalation in the person's behaviour; and
 - details the practices (and the method of application) for which authority has been provided.

- The use of the practice only occurs following application of the positive strategies (as detailed in the positive behaviour support plan) that have been designed to address the behaviour causing the person or others to be at serious risk of harm;
- On balance (when weighing up the advantages and disadvantages), the use of the practices offers benefit to the person; and
- It is the least restrictive practice in the circumstances.

Restrictive practices should never be used for reasons of efficiency or convenience.

Authority sits independently from service providers (principle 5)

The persons/services seeking to use practices such as detention, seclusion and restraint should not also be the ones providing authorisation for these practices.

In-house authorisation processes provide insufficient safeguards against the arbitrary use of detention and restraint. Service organisations (including funding departments) are too prone to be swayed by considerations of efficiency and convenience. Further, given these practices are most commonly used against people with impaired capacity who are extremely vulnerable to abuse, neglect and exploitation, in-house authorisation of such practices increases their vulnerability to cultures of abuse, neglect and exploitation that can quickly develop and thrive in 'closed environments'. Such an arrangement is also too close to the practices of the mid to late nineteenth centuries where people with disability lived in institutional environments, characterised by their custodial nature, where all decisions were made for them by institutional staff.

The importance of ensuring that the authorising entity is independent of the service that seeks to use restrictive practices was emphasised by the WJ Carter QC in his exploration of the issue to inform the regulatory scheme in Queensland.²⁸

Independent authorisation provides an important layer of scrutiny in deciding whether the practice is validated by the information provided by those seeking to use the practices, and also in considering whether the positive strategies are sufficiently robust to address the person's behaviour and thereby, over time, reduce and/or eliminate the use of restrictive practices. External input to authorisation and review processes also enables an independent perspective to inform the implementation of the plan.

In light of this, the importance of ensuring that the authorisation process is informed by appropriate clinical input cannot be over-emphasised.

Appropriate safeguards (principle 6)

Effective safeguards are an integral part of any regulatory regime for restrictive practices and should include:

- Time limits placed on the approvals/authorisations to use restrictive practices;
- Regular reviews of the decisions to authorise the use of restrictive practices; and
- The right to review/appeal the decision to allow the use of restrictive practices.

Approvals to use restrictive practices must be time-limited. While the decision-maker should have flexibility to provide the length of authorisation to suit the circumstances, there should be a limit on the authorisation of detention of 12 months and the authorisation of other restraints up to two years. Aligned with the time limits placed on approvals, there must also be regular reviews of the person's positive behaviour support plan (and the need for the use of restrictive practices), which should be conducted by the clinical team involved with the person. Finally the person (or an interested person on their behalf) should have the right to seek a review of the decision to use the restrictive practice at any time.

²⁸ Ibid.

Independent monitoring and oversight (principle 7)

Given the vulnerability of those subject to restrictive practices, particularly those residing in ‘closed environments’, independent oversight and monitoring is an absolute requirement. This should involve a two-pronged strategy including both a strong, independent complaints/oversight body and a community visitor/inspectorate arrangement.

Without independent oversight and investigative powers there is a danger that cultures of violence, abuse and neglect go unchallenged. There must be an independent statutory authority that can conduct investigations into the unlawful use of restrictive practices as well as into serious, systemic and/or unresolved allegations of violence, abuse and neglect.

The independent entity or body should have powers to receive, resolve and investigate complaints; request information and conduct investigations either in response to complaints or of its own volition; report on the outcomes of investigations; and make recommendations and/or issue directions to regulatory bodies concerning funding and registration of the service provider subject to the complaint.

Accompanying this should be a visiting/inspectorate program that conducts regular and unannounced visits in places where restrictive practices are used. These would be similar in nature to the current community visitor programs that exist in most states and territories.

The Public Advocate has made similar recommendations for such monitoring and oversight as part of the broader scheme for quality and safeguarding under the NDIS.²⁹ There would be no need to develop a separate oversight regime specifically for restrictive practices, but the complaints/oversight body and the inspectorate/visiting program should have a specific monitoring and oversight function in respect of restrictive practice use.

Reporting, data collection and evaluation (principle 8)

Behind any regulatory regime in respect of restrictive practice use should be the goals of reducing and ultimately eliminating the need to use restrictive practices.

To this end, it is generally recognised that having a reporting system to obtain and analyse evidence about restrictive practice use is crucial to adequately assessing the efficacy of any restrictive practice regime.³⁰ Unfortunately there is currently an unacceptable lack of available data and evidence to determine the effectiveness of the restrictive practice regimes that currently exist across jurisdictions, with Victoria possibly being the only exception. A legislative requirement for reporting on the use of restrictive practices is an essential part of any new statutory regime.

Not only does data provide evidence for assessing and evaluating the efficacy of existing schemes in reducing the need to use restrictive practices, it also provides for transparency and accountability in the use of such practices by service providers.

Data on the use of restrictive practices should be reported annually by the body charged with providing oversight of the scheme, and should be readily available to people with disability, their family, friends and guardians as well as statutory advocates, complaints agencies and community visitors upon request.

²⁹ See Public Advocate’s Submission to the Consultation Paper: Proposal for a National Disability Insurance Scheme Quality and Safeguarding Framework.

³⁰ Kim Chandler, Lindy Willmott and Ben White, ‘Rethinking Restrictive Practices: A Comparative Analysis’ (2014) 14 *QUT Law Review*, 121.

Assessment of Options

The Public Advocate has assessed the options for reducing and eliminating restrictive practices that are articulated in the Consultation Paper in light of the principles (1 to 8) discussed above.

Option One: Voluntary Code of Practice

A Voluntary Code of Practice is not an acceptable option. First and foremost it does not provide for the lawful use of restrictive practices, nor any of the other safeguards that are outlined above (principles 2 to 8).

Under this option there is a real danger of seeing Australia's disability services environment return to past institutional practices where the most vulnerable people with disability were subject to abuse, neglect and exploitation behind closed doors.

Option Two: Consent by a legally appointed guardian

Lawful authorisation

Without specific legislative authority, the lawfulness of appointed guardians consenting to practices such as detention, seclusion and physical restraint is at best doubtful. Drawing on principle one above, should a decision to pursue a model premised on consent by guardians be made, 'unmistakable and unambiguous language'³¹ must be incorporated into guardianship statutes to expressly allow guardians to authorise such practices (given that they represent significant infringements upon a person's rights and liberties). This is of particular importance for Queensland, Victoria, Northern Territory and Tasmania where the legislature has already provided for regulatory schemes in respect of restrictive practice use.

Further, should guardianship legislation be amended to provide authority for guardians to consent to such practices in *all* jurisdictions, then it is difficult to see why guardians would not then consent to such practices in other circumstances and environments including aged care, hospitals and rehabilitation services where people with impaired capacity are also deprived of their liberties and subject to restraints.

However, the proposal to use guardians to consent to such practices raises fundamental questions about whether guardians *should* consent to them. Such a model ostensibly places guardians in a community protection role whereas guardianship in law and equity is usually a protective jurisdiction, where decisions are only made in the best interests of the person. This creates potential tensions and conflicts for guardians. These were recognised by Williams, Chesterman and Laufer who also express that it is important to distinguish between substitute decisions (like the decision that a person should live in a particular residential facility) and a decision to admit a person to a facility that is likely to involve ongoing restrictions on their liberties.³²

Should this model be chosen, guardians should not be able to consent to detention, this role should fall to a tribunal or court such as a guardianship tribunal.

Other safeguards

Further, should guardians be chosen to lawfully authorise restrictive practices, this model must be accompanied by:

- Professional clinical input, assessment and the development of a positive behaviour support plan (see principle 2);

³¹ *Coco v R* (1994) 179 CLR 427 [10] (Mason CJ; Brennan, Gaudron, McHugh JJ).

³² Michael Williams, John Chesterman and Richard Laufer, 'Consent versus scrutiny: Restricting Liberties in Post-Bournewood Victoria' (2014) 21 *Journal of Law and Medicine*, 655.

- The involvement of independent advocates, given that guardians cannot effectively undertake this role when they have made the decision to approve the restrictive practice (see principle 3);
- Appropriate decision-making criteria (see principle 4);
- Appropriate safeguards including regular reviews of the appointment of guardians who consent to restrictive practices and tribunal decisions to approve detention (see principle 6);
- Independent monitoring and oversight (see principle 7); and
- Reporting, data collection and evaluation (see principle 8).

Option Three: Service Provider Approval

This option as it is presented is not acceptable as it does not provide for decision-making that is independent of the persons/service providers seeking to impose the restrictive practices on their clients (see principle 5).

Should legal authority be given to an expert panel to approve restrictive practices, this panel should be comprised of experts who sit independently from the service provider and should be supplemented by:

- Professional clinical input, assessment and the development of a positive behaviour support plan including the oversight of a senior practitioner (see principle 2);
- The involvement of guardians, family, friends and advocates of the person (see principle 3);
- Appropriate decision-making criteria (see principle 4);
- Appropriate safeguards including opportunities to review the decision of the expert panel, and regular reviews of the positive behaviour support plans (see principle 6);
- Independent monitoring and oversight (see principle 7); and
- Reporting, data collection and evaluation (see principle 8).

The use of detention should only be approved by an independent court or tribunal.

Option Four: Independent Authorisation

Lawful authorisation by a guardianship tribunal

Should the respective guardianship tribunals (or state administrative tribunals with appropriate jurisdiction) be given legal authority to authorise the use of restrictive practices this should be accompanied by:

- Professional clinical input, assessment and the development of a positive behaviour support plan (see principle 2);
- The involvement of guardians, family and friends of the person, but particularly independent advocates given the involvement of the guardianship tribunal (see principle 3);
- Appropriate decision-making criteria (see principle 4);
- Appropriate safeguards including regular reviews of the tribunal decision to authorise restrictive practices and opportunities for the person and other interested parties (such as the senior practitioner) to seek a review/appeal of the tribunal's decision (see principle 6);
- Independent monitoring and oversight (see principle 7); and
- Reporting, data collection and evaluation (see principle 8).

Lawful authorisation by a senior practitioner

Should a senior practitioner be given legal authority to authorise the use of restrictive practices this should be accompanied by:

- Professional clinical input, assessment and the development of a positive behaviour support plan (see principle 2);
- The involvement of guardians, family and friends of the person as well as independent advocates (see principle 3);
- Appropriate decision-making criteria (see principle 4);
- Appropriate safeguards including regular reviews of the senior practitioner's decision to authorise restrictive practices and opportunities for the person and other interested parties to seek a review of the decision to approve restrictive practices (see principle 6);
- Independent monitoring and oversight (see principle 7); and
- Reporting, data collection and evaluation (see principle 8).

Other issues

The current approach to the regulation of restrictive practices in Australia

The current approach to the regulation of restrictive practices in Australia is characterised by what has been described as a ‘hotchpotch’ of regulation.³³ Only Queensland, Victoria, Tasmania and the Northern Territory have specifically enacted legislation to regulate restrictive practice use in disability services. In other states, restrictive practices are imposed in an unregulated manner, without the ‘safeguards’ that regulatory frameworks for restrictive practices bring. Further, even in states that do regulate restrictive practice use, the regimes are limited in scope to state-funded disability services. This means that even in the four jurisdictions that have enacted legislation (Victoria, Queensland, Tasmania and the Northern Territory), restrictive practices used in privately funded services or in hospitals, aged care and other facilities are not specifically regulated.³⁴

The inconsistency of this approach, even within state jurisdictions, has been noted by various law reform commissions with the Queensland Law Reform Commission noting, for example, that:

There can be no justification, in principle, of the current two-tiered system in relation to the use of restrictive practices, under which different groups of adults have the benefit (or disadvantage, as the case may be) of differential levels of protection. Moreover, the two-tiered system that currently applies is arguably inconsistent with the United Nations Convention on the Rights of Persons with Disabilities.³⁵

The NDIS, and the national reforms in the aged care and health sectors, present an important opportunity to achieve national consistency premised on a best practice approach across a range of sectors where restrictive practices are used including disability, aged care and rehabilitation services.

The Public Advocate recommends that a review of the current restrictive practice regulatory regimes in each state and territory be undertaken. This review should be comprehensive in nature and use all available evidence to assess the efficacy of current schemes in reducing and eliminating the need for restrictive practices and improving the quality of lives of people with disability. The review should commence as soon as possible (no later than 2016) and be completed, with a national model recommended, well ahead of full implementation. In the transition period, prior to full implementation and a national scheme, states and territories will require interim legislative amendments to provide for continuing authorisation for restrictive practices. In Queensland (as in most other states) the regulation of restrictive practices is currently limited to government funded disability services.

No loss of safeguards for people with impaired capacity in Queensland

Ideally there should be a nationally consistent approach to the regulation of restrictive practices in Australia. However, in the absence of such an approach, there should be no loss of safeguards for people with disability in Queensland. The Queensland regime currently provides a relatively high level of safeguards that should not be reduced.

To do so would undermine the success that has already been achieved in respect of reducing and eliminating restrictive practice use, and also the transparency that has been achieved in relation to the provision of supports and services in which restrictive practice use is a component.

³³ Chandler, Willmott and White, above n28.

³⁴ Ibid.

³⁵ Queensland Law Reform Commission, A Review of Queensland’s Guardianship Laws (Report no 67, 2010) [19.136].

Concluding Comments

I commend the Australian Government for its considered approach to developing a quality and safeguarding framework for the National Disability Insurance Scheme.

The issue of restrictive practice use requires particularly robust consideration given the fine line between appropriately contextualised restrictive practice use (ie that which is underpinned by and contingent on a positive behaviour support approach) and the abuse, assault and neglect of people with disability, particularly those with impaired decision-making capacity.

The need for appropriate safeguards and regular scrutiny is particularly important given the history of inappropriate application of detention and restraint in the provision of services for people with disability in Australia... practices that were not only limited to the institutional environments of the past but that still prevail in modern-time service delivery. In particular, we need to safeguard against the resurgence of practices that are rightly abhorred and that fail to appropriately respect and uphold the rights and autonomy of people with disability.

The importance of ensuring a culture of openness and transparency in respect of restrictive practice use must not be under-estimated. In accordance with this, the model that is ultimately adopted **must** be one that ensures independent oversight, clinical input and appropriately objective decision-making authority.

It is critically important that any regime that gives authority to the use of restrictive practices does so in a manner that seeks to improve quality of life and ideally eliminate restrictive practice use. To do otherwise risks creating a system that binds people with disability who exhibit 'challenging' behaviour to a life of detention and restraint with minimal opportunities to achieve their true potential.

In closing, thank you for the opportunity to provide a submission in relation to the proposed quality and safeguarding framework for a NDIS. I would be pleased to further discuss the issues that I have raised in this submission should additional information be required.

Yours sincerely,



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