LAW 3527 – Law and Justice Internship

Research Essay

Introduction

Restrictive practises have long been used in the disability sector as a means of protecting individuals—often those who exhibit challenging behaviour—from harming themselves or those around them. This essay will outline the state of restrictive practises in South Australia, focusing specifically on the disability sector and the recent changes brought forth by the National Disability Insurance Scheme (NDIS). This will be done, in part, by reference to a 2019 South Australian Civil and Administrative Tribunal (SACAT) decision that highlights the inconsistent nature of restrictive practises in the State, as well as to Australia's international treaty obligations that require the fair and humane treatment of persons with a disability. Ultimately, a number of options for reform that target various issues facing the State framework will be proposed.

Restrictive Practises under the NDIS

Section 9 of the *National Disability Insurance Scheme Act 2013* (Cth) ('*NDIS Act'*) defines 'restrictive practise' as 'any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability'. Although restrictive practises are unlawful under the common law, the *NDIS (Restrictive Practises and Behaviour Support) Rules 2018* (Cth) ('*NDIS Restrictive Practise Rules 2018'*) allows certain restrictive practises to be regulated by the NDIS Quality and Safeguards Commission. Importantly, registered NDIS providers are responsible for ensuring that proper authorisation is obtained for any regulated restrictive practise in accordance with state law, with a failure to do so resulting in a civil penalty for the provider.[1] To avoid this, providers must meet a number of regulatory requirements for authorisation. First, providers must identify a NDIS participant as having behaviours of concern that places themselves or others at risk of harm, meaning authorisation of a restrictive practise against them may be necessary in the future. Under the *NDIS Restrictive Practise Rules 2018* there are five categories of regulated restrictive practises:

[1] *NDIS Act 2013 (Cth)* s 73J.

- Seclusion: 'the sole confinement of a person with disability in a room or a physical space at any hour of the day or night where voluntary exit is prevented, or not facilitated, or it is implied that voluntary exit is not permitted';[2]
- Chemical restraint: 'the use of medication or chemical substance for the primary purpose of influencing a person's behaviour' (not including medication prescribed for the treatment of a condition);[3]
- Mechanical restraint: 'the use of a device to prevent, restrict, or subdue a person's movement for the primary purpose of influencing a person's behaviour but does not include the use of devices for therapeutic or non-behavioural purposes';[4]
- Physical restraint: 'the use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour';[5] and
- Environmental restraint: 'restricting a person's free access to all parts of their environment, including items or activities'.[6]

In determining which regulated restrictive practise is necessary for a participant, a registered provider will consider what is reasonable and necessary in light of their individual circumstances and past behaviour. Importantly, the restrictive practise chosen must be considered the least restrictive response possible to achieve the outcome of protecting the individual or others.[7] There are also varying authorisation thresholds for each category, which generally consist of guardian consent, authorisation from SACAT, or both. For example, seclusion, physical restraint and mechanical restraint all require the authorisation of SACAT,[8] and physical and mechanical restraint also further require the consent of the participant's guardian. Alternatively, for chemical restraint, consent is required from an authorised guardian, and if the participant objects to the use, authorisation through SACAT is required too.

[2] *NDIS (Restrictive Practises and Behaviour Support) Rules 2018* (Cth) s 6(a).
[3] Ibid s 6(b).
[4] Ibid s 6(c).
[5] Ibid s 6(d).
[6] Ibid s 6(e).
[7] Ibid s 21(3)(d).
[8] Disability Policy Unit, 'Restrictive Practises – Protection or Breach of Rights?' (2018) *South Australian Office of the Senior Practitioner*, <https://www.ndiscommission.gov.au/sites/default/files/documents/2018-07/SA Authorisation of Restrictive Practices from 1 July 2018.pdf>, 25.

Per the *NDIS Restrictive Practise Rules 2018* (Cth), registered providers must also adhere to other criteria. First, the restrictive practise must be clearly identified in a behaviour support plan that details, among other things, the procedure and rationale for the practise.[9] Such a plan must be evidence-based, person-centred, and proactive—in other words, catering towards the participant's needs and the functions of their behaviour.[10] The rules also caution that a restrictive practise should only be used 'as a last resort in response to risk of harm to the person with disability or others, and after the provider has explored and applied evidence-based, person-centred and proactive strategies'.[11] This can be seen as a reflection of the changing attitudes on use of force against persons with a disability, which is similarly evidenced by the requirement that a restrictive practise be 'in proportion to the potential negative consequence or risk of harm'[12] and 'be used for the shortest possible time to ensure the safety of the person with disability or others'.[13] Providers are also obligated to maintain detailed records of all instances where restrictive practises are used,[14] and must provide monthly reports to the NDIS Quality and Safeguards Commission regarding the use of any restricted practises.[15] Both of these represent a commitment towards transparency and accountability, which in turn reflects a shift towards a more ethical framework underpinning restrictive practises.

The *NDIS Restrictive Practise Rules 2018* also acknowledge the right of states and territories to implement their own authorisation process for restrictive practises which operate in addition to the national framework.[16] As it stands, however, South Australia lacks a comprehensive statutory scheme to authorise and regulate restrictive practises. Rather, there are five state acts that each address some aspect of restrictive practises related to disability services: the *Guardianship and Administration Act 1993, Mental Health Act 2009, Advanced Care Directives Act 2013, Consent to Medical Treatment and Palliative Care Act 1995* and *South Australian Civil and Administrative Tribunal Act 2013*. In the absence of a unified scheme, the use of restrictive practises in South Australia is precarious, as it exposes the state government

[9] *NDIS (Restrictive Practises and Behaviour Support) Rules 2018* (Cth) s 21(3)(a).
[10] Ibid s 21(2).
[11] Ibid s 21(3)(c).
[12] Ibid s 21(3)(f).
[13] Ibid s 21(3)(g).
[14] Ibid s 15.
[15] Ibid s 14(1).
[16] Ibid s 21(3)(b).

and non-government service providers to potential criminal and civil liability due to broad inconsistencies that exist across the State framework.

Re KF; Re ZT; Re WD [2019] SACAT 37

The inconsistent and muddled nature of restrictive practise legislation in South Australia was examined by SACAT in *Re KF; Re ZT; Re WD* [2019] SACAT 37. The primary question before the Tribunal was whether restrictive practises could be authorised with the informal support of family or carers, or whether it required the consent of a guardian appointed by SACAT (with or without additional special powers authorisations from the Tribunal).[17] The case centred on three NDIS participants living in disability support accommodation, heard and determined together but remaining as separate decisions. All three individuals had been diagnosed with a significant intellectual disability that negated their ability to consent to medical treatment and decisions regarding their care.[18] As a result, a disability support worker had applied to SACAT for the authorisation of restrictive practises. The basis for the application was that under the NDIS and its accompanying rules a guardian was now required to provide consent for the use of certain restrictive practises.[19] Despite this, restrictive practises had already been used in the provision of care for each individual through consultation with their respective parents, despite none of the parents having been appointed as legal guardians under the *Guardianship and Administration Act 1993* (SA). From this, the Tribunal observed that the use of 'supported decision making' or informal consent from family members was common-place in SA, noting that 'the practice of seeking informal consent from the parents and family members of adults with impaired decision-making capacity, for most major personal decisions, has been the norm in the adult disability sector in SA for many years'.[20] The Tribunal also noted the powerful nature of guardianship orders, reflecting that a conscious incursion on an individual's autonomy to make self-determined decisions must not be 'made lightly'.[21] It is for this reason that the Tribunal emphasised the inconsistencies of the restrictive practises framework within South Australia following the introduction of the NDIS, due to the NDIS Quality and Safeguards Commission now requiring providers to seek necessary State authorisation for the use of certain restrictive practices.[22] The Tribunal noted that the

[17] *Re KF; Re ZT; Re WD* [2019] SACAT 37, [35].
[18] Ibid [10].
[19] Ibid [14].
[20] Ibid [17].
[21] Ibid [18].
[22] Ibid [38].

application of restrictive practises varied depending on the sector in South Australia, leading to:

> an inconsistency between definitions in South Australian legislation and in policy documents in use in South Australia, and a further inconsistency between the various definitions of restrictive practices in use in South Australia and the definition of restrictive practices under the NDIS Act and Rules.[23]

The Tribunal also noted the non-existence of any prior decisions that could assist with the interpretation of the different South Australian provisions and 'how they all fit together'.[24] Importantly, the Tribunal acknowledged that the definitions found within the Commonwealth *NDIS Act* and its accompanying rules were not binding on SACAT in relation to determining whether a guardian should be appointed for each of the three individuals in question, as it was the South Australian legislation that was relevant here.[25] Making this all the more difficult was the fact that the definitions for restrictive practises differ between the State and the Commonwealth, which can lead to confusion for service providers who are regulated by the Commonwealth under the NDIS but have to seek approval for restrictive practices under the State scheme. In the end, the Tribunal recognised that when read together, the *Guardianship and Administration Act 1993* (SA), *Advanced Care Directives 2013* (SA) and *Consent to Medical Treatment and Palliative Care Act 1995* (SA) all reflect a legislative approach towards recognising the differing impact of less intrusive restrictive practices and more intrusive restrictive practices.[26] Due to this, the Tribunal contrasted the differing requirements attached to these two categories, with the less intrusive restrictive practices, namely mechanical restraint, environmental restraint and chemical restraint (without the use of force or detention or enforcement powers) being dealt with by way of consent from lawful representatives.[27] (Alternatively, if there is no lawful representative then an application must be made for the appointment of a guardian, and the Tribunal may authorise a guardian to give or withhold consent to the use of a restrictive practice that does not extend to use of force or detention.) On the other end of the spectrum, more intrusive practices require a direct authorisation by the Tribunal for the use of force to implement an order, such as an accommodation or medical treatment order. The Tribunal noted that a substitute decision maker under the *Advanced Care*

[23] *Re KF; Re ZT; Re WD* [2019] SACAT 37, [42].
[24] Ibid [43].
[25] Ibid.
[26] Ibid [76].
[27] Ibid.

Directives Act 2013 (SA) or a representative under the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) may also consent to some restrictive practices in relation to medical treatment (so long as the practices are overseen by a health professional), but not extending to the use of force.

Another decision that highlighted the need for restrictive practise reform in South Australia was that of *The Public Advocate v C, B* [2019] SASCFC 58, which involved the Office of the Public Advocate (OPA) as guardian of a person detained in a residential aged care facility. In this case, the Full Court confirmed an earlier decision of the Supreme Court that said a person will be detained if they do not have the liberty 'freely to go at all times to all places'. As a result of this reasoning, protected persons residing in accommodation where they cannot leave unaccompanied—such as being unable to freely leave by reason of environmental factors such as locked doors—are therefore classed as detained in SA. This means that for detention to occur, it will need to be authorised by the SACAT making special powers orders under the *Guardianship and Administration Act 1993* (SA). Ultimately, this decision changed the understanding of restrictive practices in South Australia and highlighted the need for legislative certainty in relation to the definition of restrictive practices.

A Human Rights Perspective

Notably, a human rights movement geared towards the reduction and prohibition of restrictive practises has grown in recent years. The core argument here is that restrictive practises are abusive, archaic, and in violation of the individual's right to freedom of movement and bodily autonomy. Some even regard restrictive practises as a 'disability-specific' form of violence,[28] claiming that such acts would be considered criminal if committed against people without disability or outside an institutional setting. In general, restrictive practises are associated with a number of detrimental effects. Physically, their application can lead to serious injury and even death, particularly in instances such as seclusion where there is a heightened risk of an individual's needs being neglected. Psychologically, restrictive practises can lead to trauma, fear, shame, anxiety, depression and loss of dignity.[29] They may also lead to distrust between the individual receiving the treatment and the one carrying out the act, typically a support worker—a role that otherwise engenders a close and positive bond, which can consequently

[28] *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Restrictive Practises Issues Paper, May 2020), 2.
[29] Ibid.

lead to feelings of powerlessness and loss of independence when broken.[30] Tragically, psychological harm from restrictive practises is difficult to identify and can therefore go entirely unnoticed. The situation is especially dire when one considers just how common restrictive practises are within Australia. For example, in an 18-month period between 2018 and 2019, the NDIS Quality and Safeguards Commission received over 65,000 reports of NDIS providers carrying out unauthorised uses of restrictive practices across Australia.[31] This high figure indicates confusion and misunderstanding about the authorisation and use of restrictive practices, as well as potential exploitation and misuse of the power. It is for these reasons that Juan E. Méndez, the former United Nations Special Rapporteur on Torture, called in 2013 for all countries to introduce:

> an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities … in all places of deprivation of liberty, including in psychiatric and social care institutions.[32]

Interestingly, the Commonwealth Government in 2014 attempted to establish nationally consistent guidelines for the use and minimisation of restrictive practises through the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector,* which was endorsed by Commonwealth and state and territory disability ministers. The framework arose out of Australia's obligations under the *UN Convention on the Rights of Persons with Disabilities 2007*, and essentially outlined a number of 'high-level principles' and 'core strategies', such as a focus on human rights, person-centred solutions, education, and accountability, that together aimed to reduce reliance on restrictive practises.[33] Although the framework consequently lead to the *NDIS (Restrictive Practises and Behaviour Support) Rules 2018* (Cth), it unfortunately suffered the same fate as many other national agreements, due to it being largely aspirational and lacking any substantive proposals or legal requirement to follow it.

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[30] *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (above n 28) 2.
[31] Luke Henriques-Gomes, 'NDIS providers used unauthorised restraints more than 65,000 times, watchdog reports', *The Guardian Australia* (27 May 2020) <https://www.theguardian.com/australia-news/2020/jan/31/ndis-watchdog-is-fielding-nearly-100-allegations-of-abuse-or-neglect-a-week>.
[32] Juan E Méndez, 'Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment' (2013) United Nations Human Rights Council, [63].
[33] Department of Social Services, *National Framework for Reducing and Eliminating the use of Restrictive Practices in the Disability Services Sector* (November 2014) <https://www.dss.gov.au/sites/default/files/documents/04_2014/national_fraemwork_restricitive_practices_0.pdf>.

Australia has also agreed to a number of international conventions which relate to restrictive practices and a commitment to minimise their use, such as the *United Nations Convention on the Rights of Persons with Disabilities 2007* (UNCRPD) and the *Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment 2006* (OPCAT). Of particular importance is the latter, OPCAT, which Australia ratified in 2017. Article 1 of OPCAT explains the purpose of the treaty: to 'establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment'.[34] This system is referred to as a National Preventative Mechanism, which must be allowed to inspect 'any place under its jurisdiction and control where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence'.[35] Countries are afforded a great deal of flexibility in how they create and structure their National Preventative Mechanism—Australia chose a federated model—and as it stands, only some states and territories have implemented theirs. Nonetheless, providers that carry out restrictive practises in the disability sector would naturally fall under its scope. So although South Australia currently has no such body, the State's obligation to create one is only further reason to encourage reform for restrictive practises, as the area will eventually be regulated regardless.

The Elements of Reform

Critics of restrictive practises can be divided into two categories: reform and prohibition. Despite what some may argue, prohibition is unlikely to ever occur, as restrictive practises do serve a legitimate purpose where necessary, such as in situations where a strong chance of harm exists and no other reasonable options are available. However, it is clear that the current framework for restrictive practises is outdated, unclear, and susceptible to unauthorised use. Therefore, reform is the best option for South Australia, through number of obvious changes:

- First, there should be the creation of a new comprehensive statutory scheme to authorise and regulate the use of restrictive practises within South Australia, similar to what the Commonwealth has with the *NDIS Restrictive Practise Rules,* which would enable the rules between the Commonwealth and State to be uniform and unambiguous. Additionally, such rules would clearly outline the process for authorisation, hopefully

[34] *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 4 February 2003, 2375 UNTS 237 (entered into force 22 June 2006).
[35] Ibid art 4(1).

resolving the uncertainty facing providers about what matters need to go to SACAT for authorisation and what matters need to go to a guardian for consent.

- Second, the new scheme must be clear about which restrictive practises are prohibited and which are not, as well as explaining exactly how and when they can be applied. Further, in order to comply with international obligations, the State needs to be clear on what restrictive practices are not acceptable within the service delivery environment, so this would target that as well.
- Third, the rules must be clear that the more invasive restrictive practises (e.g. ones involving use of force) are only to be used in extreme circumstances and as a last resort, not just out of convenience, and *never* as a form of punishment. Another idea might be the creation of a hierarchy of restrictive practices that identifies those that are less and more intrusive, and providing a checklist for the authorisation of each one.
- Fourth, there must be absolute priority given to transparency and accountability (akin to what is found within the Commonwealth NDIS legislation) in order to reduce the likelihood of misuse and abuse.
- Fifth, South Australia must establish a National Preventative Mechanism in accordance with the nation's obligations under OPCAT, which will serve the purpose of carrying out inspections in the disability sector and ensuring that the rules are being adhered to (e.g. by looking at the records and talking to both workers and NDIS participants).

Ideally, all of the above changes should be as clear as possible in the legislation, as registered providers are the ones who will be interpreting and applying it. Altogether, such reforms would significantly improve South Australia's restrictive practises scheme.

Conclusion

Since the introduction of the NDIS, registered providers in South Australia are faced with uncertain rules regarding restrictive practises that are unnecessarily confusing. This includes inconsistent definitions between the State and Commonwealth as well as ambiguous authorisation requirements, both of which were evidenced in the decision of *Re KF; Re ZT; Re WD* [2019] SACAT 37. Given the controversial nature of restrictive practises, it is in the State's best interests, as well as Australia's national interests under OPCAT, to introduce a comprehensive statutory scheme that will simplify the framework and ensure that such practises are carried out only where entirely necessary and in the most ethical and transparent way possible.