Office of the Public Advocate

Safeguarding the rights and interests of people with disability

Submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

Response to the Restrictive Practices Issues Paper

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Abbreviations

APO	Authorised Program Officer
BSP	Behaviour Support Plan
CISO	Corrections Independent Support Officer
CRPD	United Nations *Convention on the Rights of Persons with Disabilities*
Code	NDIS Code of Conduct
Disability Act	*Disability Act 2006* (Vic)
DSP	Disability Service Provider
ITP Program	Independent Third Person Program
NDIS	National Disability Insurance Scheme
NDIS Commission	NDIS Quality and Safeguards Commission
NDIS Framework	NDIS Quality and Safeguarding Framework
NDIS Rules	*National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018*
OPA	Office of the Public Advocate
RNP	Registered NDIS Provider
RRP	Regulated Restrictive Practice
Royal Commission	Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
SDA	Specialist Disability Accommodation
SP	Senior Practitioner (Victoria)
SRS	Supported Residential Services
STO	Supervised Treatment Order
VCAT	Victorian Civil and Administrative Tribunal

Recommendations

Recommendation 1

The Australian Government should premise any framework designed to authorise and regulate the use of restrictive practices on appropriate human rights principles based upon the:

- United Nations *Convention on the Rights of Persons with Disabilities*
- Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment with regards to the monitoring of places of civil and criminal detention
- Australian Law Reform Commission national decision-making principles.

Recommendation 2

The Australian Government should work with State and Territory Governments to identify the appropriate authorising mechanism for social care settings when the common law doctrine of necessity is the source of authority for the temporary use of restrictive practices and there are no proper safeguards that protect human rights.

Recommendation 3

Australian jurisdictions should consider whether legislation enabling treatment-based detention should be enacted. This could be based on the model contained in Victoria's *Disability Act 2006* (Vic).

Recommendation 4

The *Disability Act 2006* (Vic) should be amended to extend compulsory treatment provisions to include all forms of cognitive impairment.

Recommendation 5

The NDIS Quality and Safeguards Commission should publish disaggregated data and detailed thematic analyses on the following:

- use of restrictive practices (for example, number of approved and unapproved restrictive practices)
- actions taken by the Commission in relation to the above.

The data should present national, State and Territory level figures, as well as year-to-year comparisons.

Recommendation 6

The Disability Ministers' forum should consider the national evaluation of Community Visitors Programs and endorse its recommendations.

Recommendation 7

The *National Disability Insurance Scheme Act 2013* (Cth) should be amended to include reference to the legislation authorising the Victorian and other Community Visitor Programs as a key component of the safeguarding arrangements in respect of NDIS funded services. Amendments should complement state laws by specifying that:

- Community Visitors are entitled to see copies of a participant's NDIS plan, provider incident reports, any documentation related to the participant's SDA tenancy arrangements, as well as the documents they are currently entitled to see when visiting (as specified in the Victorian Disability Act 2006);
- Community Visitors and other comparable entities who are appointed under state and territory legislation are entitled to share information to the extent necessary to advocate for participants and raise concerns with relevant complaints bodies.

Recommendation 8

The NDIS Quality and Safeguards Commission should provide relevant state and territories authorities with the information needed to enable these authorities to fulfil their statutory functions in relation to restrictive practices. In Victoria, this authority resides with the Senior Practitioner.

Recommendation 9

The Australian Government should work with State and Territory Governments to coordinate the design and implementation of a single national restrictive practices authorisation and regulation framework that follows the elements of the best practice framework described in this submission.

1. Introduction

The purpose of this submission is to respond to the *Restrictive Practices Issues Paper* developed by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Royal Commission).

1.1 About the Public Advocate

The Office of the Public Advocate (OPA) is a Victorian statutory office, independent of government and government services that works to safeguard the rights and interests and dignity of people with disability. The Public Advocate is appointed by the Governor in Council and is answerable to the Victorian State Parliament.

The Public Advocate has seven functions under the *Guardianship and Administration Act 2019* (Vic),[1] all of which relate to promoting the independence and human rights of people with disability and protecting people with disability from abuse, neglect and exploitation.

To this end, OPA provides a range of critical services for people with cognitive impairment or mental illness, including guardianship, advocacy, and investigation services. In 2018-19, OPA was involved in 1,823 guardianship matters (978 which were new), 404 investigations, and 258 cases requiring advocacy.[2] Forty-nine per cent of OPA's new guardianship clients were over the age of 65 and more than half (58 per cent) of OPA eligible guardianship clients were National Disability Insurance Scheme (NDIS) participants.[3]

OPA's two Disability Act officers assist the Office to fulfil its advocacy and safeguarding roles in relation to tenancy rights of people living in disability residential services, including NDIS-funded Specialist Disability Accommodation (SDA). The officers also provide individual advocacy in relation to safeguard protections involving civil detention and compulsory treatment contained within the *Disability Act 2006* (Vic) (Disability Act). These officers' interventions remain the largest single contributor to OPA's individual advocacy.[4]

A key function of the Public Advocate is to promote and facilitate public awareness and understanding about the *Guardianship and Administration Act 2019* (Vic) and any other legislation affecting persons with disability or persons who may not have decision-making capacity. To do so, OPA runs a telephone advice service, which answered 13,644 calls in 2018-19. OPA also coordinates a community education program for professional and community audiences across Victoria to engage on a range of topics such as the role of OPA, guardianship and administration, and enduring powers of attorney.

OPA is supported by more than 700 volunteers across four volunteer programs: the Community Visitors Program, the Community Guardianship Program, the Independent Third Person Program (ITP Program) and the Corrections Independent Support Officer (CISO) Program. The ITP Program is a 24/7, state-wide volunteer service operating in all police stations in Victoria. ITPs

[1] *Guardianship and Administration Act 2019* (Vic) s 15. This act came into operation on March 1, 2020 and replaces the 1986 act of the same name.
[2] Office of the Public Advocate (Vic) *Annual Report 2018-19*, (Office of the Public Advocate, 2019) 9. < https://www.publicadvocate.vic.gov.au/resources/annual-reports/opa-annual-reports>.
[3] Office of the Public Advocate (Vic) internal program data.
[4] Office of the Public Advocate (Vic) *Annual Report 2018-19*.

assist persons with cognitive impairment when making formal statements to Victoria Police. In 2018-19, ITPs attended a total of 3,222 interviews. CISOs are experienced ITPs who support prisoners who have an intellectual disability at Governor's disciplinary hearings at Victorian prisons and/or remand centres. In 2018-19, CISOs were invited to attend 299 hearings, assisting 164 clients.

Community Visitors are independent volunteers empowered by law to visit Victorian accommodation facilities for people with disability or mental illness. They monitor and report on the adequacy of services provided in the interests of residents and patients. They ensure that the human rights of residents or patients are being upheld and that they are not subject to abuse, neglect or exploitation. In their annual report, Community Visitors relate their observations on the quality and safety of the services they visit and make recommendations to the Victorian State Government. More than 400 Community Visitors visit across three streams: disability services, supported residential services (SRS), and mental health services. In 2018-19, Community Visitors made 5,527 statutory visits, including to sites of criminal and civil detention.[5]

1.2. OPA's Engagement with the Royal Commission

OPA welcomes the continued opportunity to contribute to this Royal Commission. The Public Advocate and two Community Visitors appeared as witnesses before the Royal Commission at its December 2019 hearings in Melbourne to speak about violence in group homes. In November 2019, OPA released a report, *I'm too scared to come out of my room,* that was submitted to the Royal Commission in response to the *Group Homes* Issues Paper. In March 2020, OPA contributed a written submission to the Issues Paper on *Health care for people with cognitive disability*. In May 2020, OPA made a written submission in response to the Issues Paper on *The Criminal Justice System.* In July 2020, OPA made a submission to the *Emergency Planning and Response* Issues Paper and in August 2020, OPA made a written submission to the *Rights and Attitudes* Issues Paper. OPA is also preparing to respond to further requests for information from the Royal Commission, including this *Restrictive Practices* Issues Paper, and *The Experience of First Nations People with Disability in Australia* Issues Paper.

1.3. Previous OPA Work on Restrictive Practices

OPA would like to draw the attention of the Royal Commission to its previous work that discusses restrictive practices. OPA discussed the issue of restrictive practices in the Victorian mental health system in its *Submission to the Royal Commission into Victoria's Mental Health System* (2019) and will not discuss it any further in this submission.[6]

In its submission responding to this Royal Commission's Issues Paper on *Health Care for People with Cognitive Disability*, OPA discussed the validity of civil detention and the doctrine of necessity as a justification for depriving someone of their liberty without their consent. It referred the Royal Commission to *Designing a deprivation of liberty authorisation and regulation framework* (2017) an OPA publication that laid out preliminary thinking on the design of such a civil detention

[5] Office of the Public Advocate (Vic), *Community Visitors Annual Report 2018-19*.
[6] This submission is available on OPA's website: Office of the Public Advocate (Vic.) *Submission to the Royal Commission into Victoria's Mental Health System* (Office of the Public Advocate, 2019).
< https://www.publicadvocate.vic.gov.au/resources/submissions/mental-health-1>

framework.[7] That paper discusses the issue of civil detention in social care settings in extensive detail and OPA refers the Royal Commission to it once more.

1.4. A Human Rights Approach

This submission applies a human rights approach that:

- holds that all people with disability have the right to enjoy equality of opportunity and to effectively participate in, and be fully included in, society
- recognises that the vast majority of challenges experienced by people with disability are a result of disabling systems and environments, rather than being due to an inherent 'lack' in the individual
- considers impairment as an expected dimension of human diversity
- seeks for people with disability to be supported and resourced to have the capabilities to lead a dignifying and flourishing life.

1.5. The Structure of this Submission

This submission proposes an overarching framework for the regulation and monitoring of restrictive practices in the disability sector, using the human rights approach discussed in section 1.4. above. But the framework could be applied in other social care settings.

This submission will detail this framework and the human rights principles upon which it is based. It will discuss:

- key principles of a safeguarding framework for restrictive practices
- the regulatory principles of this framework.

The submission will then discuss the existing legal frameworks in Victoria that can be used to authorise civil detention of people with intellectual disability. Because of the transition to the NDIS, Victoria currently has a hybrid system. The elements of the two systems will be outlined and then the final section will outline OPA's preferred framework for regulating restrictive practices based on a robust human rights approach.

2. Key Principles of a Safeguarding Framework for Restrictive Practices

At common law, the use of restrictive practices such as any type of restraint, would constitute a criminal offense if not properly authorised. There are exceptions, recognised at common law, that restraint can be used lawfully in an emergency or out of necessity until proper, lawful, authorisation is obtained. The use of restraint seriously affects a person's human and legal rights, and its use must be justified in each instance.

[7] Eleanore Fritze, *Designing a Deprivation of Liberty Regulation and Authorisation Framework: A Discussion Paper* (Office of the Public Advocate, 2017). <https://www.publicadvocate.vic.gov.au/resources/research-reports/restrictive-practices>

2.1. What are Restrictive Practices?

The Royal Commission in its issues paper on restrictive practices draws upon the definition in the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector,* agreed to by all Commonwealth, State and Territory Ministers in 2013.
These restrictive practices are:

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. (Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person.)

Chemical restraint – the use of medication or chemical substance for the primary purpose of influencing a person's behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.

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.

Environmental restraint – restrict a person's free access to all parts of their environment, including items or activities. Environmental controls such as locked doors, keypad controls on doors, perimeter fences and other building design features may restrict an individual's freedom to come and go at will. Similarly, being constantly supervised or escorted by staff also severely restricts a person's liberty.

Psychosocial restraint – constantly telling a person that doing an everyday activity is too dangerous, without reasonable justification.

Seclusion – the sole confinement of an individual 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. [8]

2.2. Principles of a Framework to Regulate Restrictive Practices

A distillation of common law principles suggests that any framework for the regulation of restrictive practices which deprives a person with disability of their liberty, who does not have the capacity to consent, should be done only:

- for therapeutic purposes to benefit the person, or prevent the person from harming themself or another, and any restrictions on their liberty should occur only for the minimum time necessary
- in the least restrictive way possible in the circumstances
- when authorised by an appropriate legal body with the person having the right for appropriate appeal and review processes

[8] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability *Restrictive Practice Issues Paper* (Royal Commission 2020) 1-2, 10n.3.

- with appropriate independent advocacy support being provided during this process.[9]

Such principles are consistent with the human rights enshrined in the United Nations *Convention on the Rights of Persons with Disabilities* (CRPD), particularly Article 12 (Equality before the Law) and Article 14 (Liberty and Security of Persons). The United Nations Optional Protocol to the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* is also relevant here in relation to the human rights principles of civil detention and its independent monitoring. In the Australian context, similar principles are also contained in the Australian Law Reform Commission's recommended national decision-making principles. There are four key principles:

- Principle 1: The equal right to make decisions – all adults have an equal right to make decisions that affect their lives and to have those decisions respected.
- Principle 2: Support – persons who require support in decision-making must be provided with access to the support necessary for them to make, communicate and participate in decisions that affect their lives.
- Principle 3: Will, preferences and rights – the will, preferences and rights of persons who may require decision-making support must direct decisions that affect their lives.
- Principle 4: Safeguards – laws and legal frameworks must contain appropriate and effective safeguards in relation to interventions for persons who may require decision-making support, including to prevent abuse and undue influence.[10]

Recommendation 1
The Australian Government should premise any framework designed to authorise and regulate the use of restrictive practices on appropriate human rights principles based upon the:

- **United Nations *Convention on the Rights of Persons with Disabilities***
- **Optional Protocol to the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* with regards to the monitoring of places of civil and criminal detention**
- **Australian Law Reform Commission national decision-making principles.**

3. Existing Legal Mechanisms for Civil Detention in Victoria

The current system for civil detention in Victoria is complex. Multiple systems exist. Some social care institutions such as the general hospital system do not have an appropriate legislative human rights framework to regulate restrictive practices in line with the principles outlined in section 2.2. above.[11] But the disability system has a hybrid mix of State and Commonwealth legislation that can

[9] HL v United Kingdom [2004] ECHR 471
[10] Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws (*Australian Law Reform Commission, 2014) 24, cited in Office of the Public Advocate, *Submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability: The Criminal Justice System Issues Paper (*Office of the Public Advocate, 2020) 11.
< https://www.publicadvocate.vic.gov.au/resources/submissions/royal-commission-into-violence-abuse-neglect-and-exploitation-in-disability-care>
[11] This discussion excludes the public mental health system in Victoria, which has a system of regulated restrictive practices and appropriate human rights safeguards in the *Mental Health Act 2014* (Vic).

cause confusion. This section will discuss each of these systems and describe any common elements that could be used to create one system based on a human rights approach.

The existing mechanisms for civil detention in Victoria are:

- emergency situations – common law
- civil detention under the *Disability Act 2006* (Vic)
- NDIS Quality and Safeguarding Framework.

3.1. Silence is Not Consent: The Common Law Doctrine of Necessity

OPA discussed the use of unregulated restrictive practices in social care settings such as hospitals in its paper on health care for people with cognitive disability to this Royal Commission.[12] The story of 'Oliver' highlighted OPA's concern about restrictive practices being used without a proper authorising legal framework to sanction and review the restrictions in situations where a person cannot consent or does not object to the restrictive practice.[13] This 'gap' in the safeguarding framework in Oliver's case may have been justified through the common law doctrine of necessity. However, the doctrine of necessity can only be relied upon in the short-term.[14] According to this doctrine, the law of necessity should only be relied upon for the period of time it takes to make an application to a lawful authority (such as VCAT) and for that body to hear the case and make a determination on the lawfulness or otherwise of the restrictive practice.

Recommendation 2
The Australian Government should work with State and Territory Governments to identify the appropriate authorising mechanism for social care settings when the common law doctrine of necessity is the source of authority for the temporary use of restrictive practices and there are no proper safeguards that protect human rights.

3.2. Restrictive Practices Regime Under the *Disability Act 2006* (Vic)

This section will describe the elements of the safeguarding framework that is outlined in Part 7 of the Disability Act and how these elements are replicated with some modifications in Part 6B of that Act in relation to NDIS participants. Each of the key legal steps are in bold type with relevant details relating to each step below it. These key elements are:

3.2.1. Legal Authorisation

- A Disability Service Provider (DSP) must be authorised to use Restrictive Practices (RP) on a person with disability.
- The DSP appoints an Authorised Program Officer (APO).

[12] Office of the Public Advocate (Vic.), 'Submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability: Health care for people with cognitive disability' (Office of the Public Advocate, 2020). < https://www.publicadvocate.vic.gov.au/resources/submissions/royal-commission-into-violence-abuse-neglect-and-exploitation-in-disability-care> This issue is also discussed extensively in Fritze, *Designing a Deprivation of Liberty Regulation and Authorisation Framework.*
[13] Office of the Public Advocate, 'Health care for people with cognitive disability' 16-17.
[14] Michael Williams, John Chesterman and Richard Laufer "Consent versus scrutiny: Restricting liberties in post-Bournewood Victoria". (2014) 21 *Journal of Law and Medicine* 641-60.

- The DSP must inform the Victorian Senior Practitioner (SP) of the name and qualifications of the APO.

3.2.2. Clinical Oversight and Approval

- When are regulated restrictive practices (RRPs) permitted?[15]
  - The APO must include the RRPs in a Behaviour Support Plan (BSP) and specify their purpose and period of usage
  - The APO must provide the SP with a copy of the BSP
  - The SP must authorise the use of RRPs (if they are to be used) and provide clinical oversight
  - The SP can require a DSP to provide a report on the use of RPs which are not RRPs
  - The SP can issue clinical guidelines and standards on RPs that require additional authorisation.[16]

3.2.3. Independent Support

- An independent person is engaged to help person with disability understand the use of RRPs and their appeal rights.

3.2.4. Review and Appeal

- DSP to review the BSP at least every 12 months.
- The person can appeal the inclusion of RRPs in their BSP and any authorisation of their use by the SP to VCAT.

3.2.5. Breaches of the Legislation

- DSP commits an offence if applies RRPs contrary to the Disability Act.

Appendix A is a visual map of Part 7 of the Disability Act.

3.2.6. Special Authorisation

Where RRPs are really being used for the protection of others, this requires special authorisation as it is not about the person's benefit, but for the benefit of others. This should not be approved through guardianship. This special authorisation process may require the use of the Supervised Treatment Order (STO) process under Part 8 of the Disability Act.

[15] RRPs are authorised by the SP under s. 145A of the *Disability Act* 2006 *(Vic)*. The SP can only authorise seclusion, physical or mechanical restraint or a practice subject to the direction of the SP issued under that section of the act.
[16] *Disability Act* 2006 (Vic) s 150.

3.3. Supervised Treatment Orders

Victoria has a system of authorisation of RRPs where civil detention is required. These are regulated through an order of VCAT and is called a supervised treatment order (STO).[17] To detain a person on an STO under the Disability Act includes the practices of (1) physically locking a person in any premises, and (2) constantly supervising or escorting them to prevent the person from exercising freedom of movement. These are forms of environmental restraint.

The elements of an STO are described at length in OPA's paper to the Royal Commission on the criminal justice system. STOs currently only apply to people with an intellectual disability, but as recommended in that submission, OPA believes that this system should apply to all people with cognitive impairments who would benefit from it. What follows draws heavily from the section on STO in the criminal justice submission to this Royal Commission.[18]

STOs, as a civil regime, has the advantage of intervention at an earlier point than the criminal justice system; in this way, they can divert persons away from the criminal justice system into the community, albeit with augmented supports and supervision. In OPA's view, the effectiveness of the STO regime is largely due to its matrix of elements:[19]

- Development of a treatment plan includes the engagement of skilled professionals, the scrutiny of the SP who must approve the plan, and VCAT which must make the STO having regard to the plan
- External bodies are involved in regulating and scrutinising the use of STOs (VCAT, the Senior Practitioner, and OPA) and are obliged to ensure that the rights, dignity and interests of the person with the intellectual disability are protected.
- Victoria Legal Aid's specialist advocacy for persons proposed for, or subject to, detention.

One of OPA's concerns in relation to STOs is that a person could become subject to de facto continuous detention by reason of consecutive renewal of applications. OPA stresses the importance of the careful application of safeguarding processes and bodies to prevent this happening. The emphasis of STOs is on reducing levels of supervision and increasing independent freedom of movement where risks can be managed; in this sense, STOs offer greater flexibility to manage individuals with cognitive impairment who pose a significant risk of serious harm to others than the usual mainstream correctional arrangements.

While people who are on STOs gain access to high quality services and clinical oversight from the Senior Practitioner, those not on an STO are denied access to the same level of funded treatment, services, and safeguards. Essentially, this means that a person's access to the benefits and safeguards associated with supervised treatment is made conditional on their detention. OPA considers the Victorian STO process could be a model for other jurisdictions to consider for all people with cognitive impairment who would benefit from it. This process would prevent people with cognitive impairment from being arbitrarily detained outside the STO system.[20]

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[17] The provisions related to an STO are in the *Disability Act (2006)* (Vic.) s. 183 onwards.
[18] The section on STO is in Office of the Public Advocate, 'Criminal Justice System Issues Paper' 32-36.
[19] These elements are outlined in the *Disability Act* 2006 (Vic) s. 191 onwards.
[20] Office of the Public Advocate, 'Criminal Justice System Issues Paper' 33-34.

Recommendation 3
Australian jurisdictions should consider whether legislation enabling treatment-based detention should be enacted. This could be based on the model contained in Victoria's *Disability Act 2006* (Vic).

Recommendation 4
The *Disability Act 2006* (Vic) should be amended to extend compulsory treatment provisions to include all forms of cognitive impairment.

3.4. The NDIS Quality and Safeguarding Framework

The key elements of the NDIS Quality and Safeguarding Framework against the inappropriate use of restrictive practices are described below. In this section, OPA draws heavily on its recent submission to the Joint Standing Committee on the NDIS' *Inquiry on the NDIS Quality and Safeguards Commission*.[21]

3.4.1. The NDIS Code of Conduct (the Code)

The Code states that all NDIS providers and workers must contribute to the reduction and elimination of restrictive practices yet provides little guidance on how to work practically towards this goal.

3.4.2. The National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 (NDIS Rules)

The NDIS Rules differ from the Royal Commission definition of restrictive practices because section six does not include psychosocial restraint in its definition of RRP.

Rule 9 of the NDIS Rules points to the hybrid nature of the current system, as the use of RRP specified in rule 6 of the NDIS Rules (Commonwealth legislation) must be authorised by existing state and territory legislation.

3.4.3. The NDIS Quality and Safeguards Commission (NDIS Commission)

In the NDIS context, only registered providers can deliver behaviour supports and therefore administer authorised restrictive practices. This should not be taken to mean that unregistered workers (or providers) are not administering unauthorised restrictive practices, either willingly or inadvertently. Every unauthorised restrictive practice that is administered must be reported to the NDIS Commission, and behaviour support specialists and other providers will be across their requirements to do so. However, OPA is doubtful that sufficient guidance is contained in the Code to explain to unregistered workers and providers what constitutes a restrictive practice and when to report its use.

In the consumer-driven market environment of the NDIS, the publication of information about providers, including their use of restrictive practices, should be an indispensable mechanism to

[21] Office of the Public Advocate, *Joint Standing Committee on the NDIS: Inquiry on the NDIS Quality and Safeguards Commission* (Office of the Public Advocate, 2020). <https://www.publicadvocate.vic.gov.au/resources/submissions>.

equip participants with the tools and knowledge to be informed purchasers and consumers of NDIS supports. Through public reporting, the NDIS Commissioner enacts core functions and fulfils the objects of the *National Disability Insurance Scheme Act 2013* to support the independence of people with disability, and, more importantly, to enable people with disability to exercise choice and control in the pursuit of their goals, and the planning and delivery of their supports.

Recommendation 5
The NDIS Quality and Safeguards Commission should publish disaggregated data and detailed thematic analyses on the following:

- **use of restrictive practices (for example, number of approved and unapproved restrictive practices)**
- **actions taken by the Commission in relation to the above.**

The data should present national, State and Territory level figures, as well as year-to-year comparisons.

3.4.4. The NDIS Quality and Safeguarding Framework (the NDIS Framework)

The NDIS Framework adopts a human rights framework in line with the CRPD to reduce the use of restrictive practices as much as possible. OPA welcomes this approach and the NDIS Framework's support of the crucial safeguarding role of Community Visitors. While Community Visitors' programs exist in most States and Territories, their operating parameters slightly differ. In Victoria, Community Visitors are independent volunteers who are empowered by legislation to visit disability 'residential services', 'SDA enrolled dwellings where there are SDA residency agreements in place', 'short-term accommodation and assistance dwellings', 'designated mental health services' and 'SRS'. Community Visitors play a vital safeguarding role for people with disability, providing independent on-site monitoring of service delivery and accommodation standards, as well as referring concerns to relevant bodies as required. The legislated powers of Community Visitors enable them to assess services on the ground and through their annual reports, the Community Visitors Boards make recommendations to the Victorian Government on systemic improvements to drive positive change.

The Community Visitors scheme applies a monitoring model, which is crucial for people with disability who, by reason of cognitive impairment and/or a history of disempowerment, may be unable to contact an advocate or may not recognise that they could benefit from the support of an advocate. Community Visitors are often referred to as the 'eyes and ears' of the community because, for some residents, Community Visitors are the only unpaid and independent people in their lives.

One of the most important aspects of the Community Visitors' role is the reporting of abuse matters. It is, however, a complex area for a variety of reasons: residents may be unable to report what has happened or they may not perceive what has happened to them as abuse. Community Visitors can assist in this area and, importantly, keep service providers accountable.

The NDIS framework attributes a safeguarding role to Community Visitors for the duration of the transition to the NDIS. An independent national evaluation of the various Community Visitors

schemes across Australia was undertaken to assist the Disability Reform Council (DRC)[22] in determining what the continued role of the visitors should be at full scheme. The evaluation report is dated December 2018. This evaluation recognised the contributions of Community Visitors and recommended their continuation at full scheme. The report made two key recommendations:

- the role of Community Visitors should continue to be provided by state and territory-based schemes where they exist
- to support Community Visitors schemes' interface with the NDIS Commission, the following matters should be agreed between the NDIS Commission and states and territories:
    - authority of Community Visitors to enter the premises of NDIS providers
    - data and information sharing
    - compulsory reporting to the NDIS Commission on alleged reportable incidents and failure to adhere to incident management processes
    - reporting on patterns of concern to the NDIS Commission and State/Territory agencies
    - role of Community Visitors Scheme in relation to restrictive practices monitoring and reporting.[23]

The implementation of the above recommendations is at least in part conditional on the endorsement of the Disability Ministers' forum (previously known as Disability Reform Council). The Victorian Government has a long-standing commitment to maintain the Community Visitors Program while awaiting a decision on the ongoing role of Community Visitors from Disability Ministers. The Royal Commission's support of the above recommendations would facilitate the work of Community Visitors and be an important recognition of their contribution to safeguarding in the NDIS.

Recommendation 6
The Disability Ministers' forum should consider the national evaluation of Community Visitors Programs and endorse its recommendations.

Recommendation 7
The *National Disability Insurance Scheme Act 2013 (Cth)* should be amended to include reference to the legislation authorising the Victorian and other Community Visitor Programs as a key component of the safeguarding arrangements in respect of NDIS funded services. Amendments should complement state laws by specifying that:

- **Community Visitors are entitled to see copies of a participant's NDIS plan, provider incident reports, any documentation related to the participant's SDA tenancy arrangements, as well as the documents they are currently entitled to see when visiting (as specified in the Victorian Disability Act 2006);**

[22] OPA is aware that National Cabinet has announced a review of the former Council of Australian Government (COAG) Councils, including the Disability Reform Council (DRC). As noted in the Statement from the 24 July 2020 meeting: "While the review is underway, disability ministers continue to meet to discuss critical issues of national significance in accordance with agreed protocols and the *National Disability Insurance Scheme Act 2013* (Cth). The future form and role of a disability ministers' forum will be determined under the revised Ministerial Forum structure, including progressing current actions".
(Meeting of Commonwealth, State and Territory Disability Ministers (Government of Australia). *Statement* (24 July 2020)).
[23] Department of Social Services, *Community Visitors Schemes Review* (Department of Social Services, 2018) 11.

- **Community Visitors and other comparable entities who are appointed under state and territory legislation are entitled to share information to the extent necessary to advocate for participants and raise concerns with relevant complaints bodies.**

3.4.5. Intersection with Victorian law

As noted above, in section 3.2, the NDIS Framework intersects with State and Territory laws regarding the authorisation of RRPs. In Victoria, the use of RRPs in relation to NDIS participants is regulated by Parts 6A and 6B of the Disability Act.

Parts 6A and 6B are modelled on Part 7 that is set out above. But there are differences resulting from the regulation of RRPs under the NDIS (Restrictive Practices & Behaviour Support) Rules 2018 and the regulation of NDIS registered providers through the NDIS Quality and Safeguarding Commissioner.

Registration

In Part 6A of the Disability Act, unlike Part 7, there is no requirement that the registered NDIS provider be approved to use RRPs in Victoria as these matters are covered by the NDIS (Restrictive Practices & Behaviour Support) Rules 2018 (see Part 2).

But like Part 7, Part 6A sets out the requirement that a registered NDIS provider must appoint an APO, a person approved by the SP. If the SP refuses to approve the APO, he must inform the NDIS Commissioner.

BSP

Like Part 7, there is a requirement that the use of RRPs is authorised by the APO. How RRPs are included in a BSP is governed by the NDIS (Restrictive Practices & Behaviour Support) Rules, which provide that the BSP is developed by a specialist behaviour support practitioner following a process set out in the Rules.

Like Part 7, the SP must approve certain RRPs (essentially seclusion, physical restraint and mechanical restraint).

Independent Person

Like Part 7, the APO must engage an independent person to explain the use of RRPs in the participant's plan and that the person has appeal rights about the inclusion of the RRPs and their approval by the SP.

Review and Appeal

The participant can appeal to VCAT about the inclusion of the RRPs in the BSP, but VCAT's powers differ and can include an order the NDIS registered provider seek a review of the participant's BSP by an NDIS behaviour support practitioner. Notably, VCAT cannot require that

there be such a review as a review will depend on the agreement of the NDIS planner. VCAT can direct that the RRP not be used on the participant.

According to the NDIS (Restrictive Practices & Behaviour Support) Rules 2018, a BSP must be reviewed at least every 12 months and earlier if there has been a change of circumstances. (Rule 22)

Offences

Unlike Part 7 in relation to DSPs, there are no offences in the Disability Act in relation to misuse of RRPs by an NDIS provider.

Discipline of NDIS registered providers is governed by the NDIS (Restrictive Practices & Behaviour Support) Rules and the NDIS Act 2013. These Rules remind NDIS registered providers that a failure to comply with the Rules may result in a civil penalty under s73J of the NDIS Act 2013 and offences under the Commonwealth's Criminal Code in relation to false or misleading statements, information and documents.

Intersection between Victorian law and the NDIS system

Critically, Victorian law adds clinical oversight and appeal rights to the NDIS system set out in the NDIS (Restrictive Practices & Behaviour Support) Rules 2018. However, the relationship between Victorian law and the NDIS approach is complex which will make compliance more difficult to obtain and sustain.

To some degree, Victorian clinical oversight and VCAT orders to review a participant's BSP are dependent on convincing the participant's planner to review the plan to fund a BSP review. Clinical concerns and VCAT orders could be negated if the planner is unconvinced that a review is necessary.

Monitoring

NDIS providers must provide monthly reports to the NDIS Commission on the use of restrictive practices and should provide the SP with reportable incidents to monitor the authorisation process. The use of a restrictive practice that is not in a BSP is a reportable incident that must be reported to the NDIS Commission within five days.

This information is not shared with the SP. However, there is a need for an information sharing protocol between the NDIS Commission and the SP. This sharing of information is crucial to the functioning of the SP. The functions of the SP are set out in s.24 of the Disability Act, in particular: to develop guidelines and standards, to give directions to NDIS providers, to undertake research into RPs, and to evaluate and monitor the use of RPs.

Appendix B is a visual map of Part 6B of the Disability Act.

Recommendation 8
The NDIS Quality and Safeguards Commission should provide relevant state and territories authorities with the information needed to enable these authorities to fulfil their statutory functions in relation to restrictive practices. In Victoria, this authority resides with the Senior Practitioner.

4. What are the Elements of a Best Practice Framework for Restrictive Practices?

OPA would like now to put forward what it considers are the elements of a best practice framework for regulating and monitoring restrictive practices to ensure the human rights of the person with disability are upheld and promoted.

The elements of a best practice framework are:

- registration of an organisation to use restrictive practices
- identification within organisations of a person qualified to authorise the use in relation to particular persons and to be responsible for their use and implementation
- the development of a BSP that follows guidelines in NDIS Rules
- that the use of certain restrictive practices is approved by a state authorised body
    - physical
    - mechanical
    - seclusion
    - chemical
    - environmental restraint where it amounts to, or approximates, detention of the person
- that the use of certain restrictive practices is explicitly proscribed by the State such as the use of aversive therapy or 'consequence driven practices', for example, that involve removing activities or items from a person[24]
- scope for expansion of the list of these proscribed practices by the State (for example, in Victoria it could be by the Senior Practitioner)
- that the State supervising body have clinical oversight and is resourced appropriately
- that the use of restrictive practices is monitored
    - by the authorising officer
    - by the organisation authorised to use restrictive practice
    - through reporting to the approving or supervising body
    - through inspection, by the Community Visitors Program in Victoria, or equivalent in other States or Territories
- the authorising officer must explain to the person the use and purpose of the restrictive practices
- an independent person must also explain to the person the use and purpose of the restrictive practices

The person:

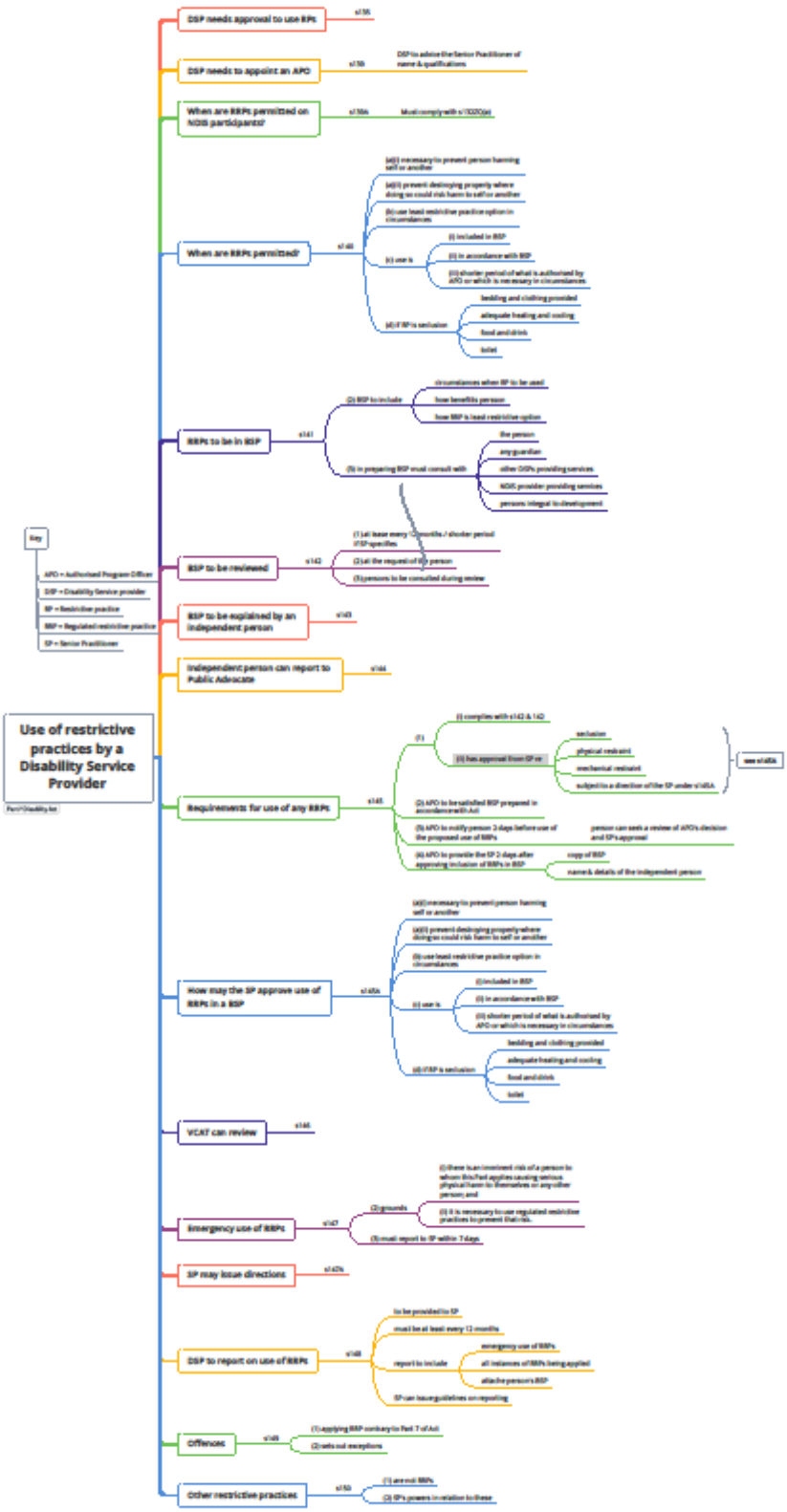
- can appeal against the use of restrictive practices

[24] Consequence - driven practices are defined in the Department of Social Services, *Quality and Safeguarding Framework* (Department of Social Services, 2016) 67 (Box 5).

- must have access to advocacy support to ensure this is a right that can effectively be exercised
- the powers of the monitoring and supervising bodies to be clearly stated, especially how they can exert authority to protect the person from the misuse or inappropriate use of restrictive practices
- here should be offences and penalties for misuse or inappropriate use of restrictive practices.

Recommendation 9
The Australian Government should work with State and Territory Governments to coordinate the design and implementation of a single national restrictive practices authorisation and regulation framework that follows the elements of the best practice framework described in this submission.

Attachment A: Mindmap Part 7 *Disability Act 2006* (Vic.)



Attachment B: Mindmap Part 6B *Disability Act 2006* (Vic.)