National Disability Services

NSW Law Reform Commission: Review of the Guardianship Act NSW 1987

Responses to Question Paper 5: Restrictive Practice Regulation

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About National Disability Services

National Disability Services ('NDS') is the peak body for non-government disability services. Its purpose is to promote quality service provision and life opportunities for people with disability. NDS's Australia-wide membership includes more than 1050 non-government organisations, which support people with all forms of disability. NDS provides information and networking opportunities to its members and policy advice to state, territory and federal governments.

NDS responses to Question Paper 5:

Questions 7.1 to 7.8 on Restrictive Practice regulation

Question 7.1: Problems with regulation

What are the problems with the regulation of restrictive practices in NSW and what problems are likely to arise in future regulation?

Lack of awareness of restrictive practices and a risk management culture

The past decade has seen increased public and policy awareness of the issue of restrictive practices in Australia. Though at a practical level, across *some* disability organisations and more so among mainstream service sectors, there is still a lack of awareness of what constitutes a restrictive practice and therefore the need for them to be properly regulated.

Some other barriers include a risk management culture rather than positive approaches to behaviour support, lack of staffing and staff supervision, lack of adequate education for staff, and client stigmatisation (a perception that care of the person requires restraint based on the person's characteristics or diagnosis).[1] Therefore, any discussion of regulation must recognise the importance of removing these barriers though capacity-building and education about the human rights context of restrictive practices.

In the National Disability Insurance Scheme (NDIS) landscape, a future challenge will be for organisations to understand the importance of implementing strategies to reduce the use of restrictive practices. This is because restrictive practices by their nature reduce a person's control and choice and impede a person's access to valued roles in community life.[2]

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[1] Australian Psychological Society. (2011). *Evidence-based guidelines to reduce the need for restrictive practices in the disability sector*. [online] Available at: https://www.psychology.org.au/assets/files/restrictive-practices-guidelines-for-psychologists.pdf at 9

[2] JFA Purple Orange, *Public discussion paper prepared for the ACT Government, to assist public consultation:* An overview of restrictive practices, and the key issues for consideration in relation to the establishment of an Office of the Senior Practitioner, January 2017 at 8http://www.actosp.org.au/application/files/7714/8574/9786/An_overview_of_restrictive_practices_and_the_key_issues_for_consideration_in_relation_to_the_establishment_of_an_Office_of_the_Senior_Practitioner_January_2017.pdf

Capacity building of people with disability

People with disability who are subject to restrictive interventions are often highly vulnerable, have limited communication abilities and there is a significant potential for their human rights to be violated and for abuse to occur. People with a disability should also be aware of, and be supported to access, sources of independent advice and advocacy prior to their agreeing to the implementation of any programs or procedures, especially those that are or could be restrictive in any way.[3]

People with disability have the right to make decisions about matters which affect their life, including in relation to the use of restrictive practices. As a result, any approach must ensure that decisions about, and consent to, restrictive practices are ultimately those of the person on whom the practice is being used.[4]

The sustainability of Restrictive Practice Authorisation Panels ('RPAPs')

The NSWLRC would be aware of the Family and Community Services' (FACS) policy directive[5] ('The Policy Directive') that applies to services run or funded by the FACS division of Ageing, Disability and Home Care ('ADHC'). The policy requires authorisation from an appropriate person or body (e.g. a specialist panel including clinical experts) *and* informed legal consent. Large disability organisations have typically staffed restrictive practice authorisations panels ('RPAPs') with in-house clinicians. On the other hand, small organisations have come together in a collaborative spirit by sharing each other's clinicians input into a RPAP.

Some of these organisations also rely on independent clinicians from ADHC to sit on RPAPs. However, once all NSW participants have transferred to the NDIS by 30 June 2018, ADHC will cease to exist and policies currently regulating the use of restrictive practice and RPAPs in the disability sector will no longer apply. NDS members have stated that convening RPAPs without the advice and often input of ADHC clinicians will place a burden on providers. As

[3] Australian Psychological Society, above n1, at 14
[4] ALRC, National Decision making principles, https://www.alrc.gov.au/publications/national-decision-making-principles
[5] ADHC's *Behaviour Support Policy (2009);* *https://www.adhc.nsw.gov.au/sp/delivering_disability_services/behaviour_support_services/behaviour_support_policy_and_practice_manual*

noted, providers are already struggling with a lack of capacity within their organisations, and perhaps more broadly in the industry, in designing and delivering alternatives to restrictive practices.[6]

Perhaps the greatest challenge created by the NDIS is that of resourcing/funding the RPAPs. NDS members report inadequate pricing levels under the NDIS. They note that many NDIS participants do not have the evidence available to support the level of funding they need to receive positive behaviour support under the NDIS and there is a lack of consistency and knowledge from Local Area Coordinators (LAC) to capture support needs within the NDIS planning process. Therefore, it is unlikely that there will be sufficient funding to convene a RPAP. This means that the reality for some providers is that they will seek to apply restrictive practices without RPA. Potentially, the use of restrictive practices 'will go underground' exposing organisations to civil and criminal liability.

Under ADHC policy and best practice, it is important that the decision-maker who authorises the use of restrictive practices is independent from the clinician who is drafting the behaviour support plan (BSP) or who seeks to use restrictive practices.[7] While independence has always been a challenge it will potentially become more pronounced under the NDIS. Operationally under the NDIS funding model, it will be difficult to understand how organisations will pay for each other's time to sit on panels compared with the currently more flexible ADHC block-funding system.

NDS is concerned about the increased potential for the unregulated use of restrictive practices. We believe that serious restrictive interventions require independent legal authorisation. Clarity is needed on where the responsibility for seeking authorisation sits and the level of authorisation required. This will be discussed in greater detail in response to subsequent questions.

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[6] JPA Purple Orange, above n2, at 14

[7] ADHC, Behaviour Support: Policy and Practice Manual Guidelines for the provision of behaviour support services for people with an intellectual disability Part 2: ADHC procedures and templates; *https://www.adhc.nsw.gov.au/sp/delivering_disability_services/behaviour_support_services/behaviour_support_policy_and_practice_manual* at 19

Lack of consistent approaches

Service responses within the disability sector are also variable and inconsistent. Providers have varied policies and procedures in place to deal with restrictive practices, making it difficult for service users who use a wide range of services. While we expect that the Senior practitioner set up by the NDIS Quality and Safeguarding Framework ('NDIS Framework') and forthcoming legislation will have a role in overseeing service providers[8], the level of detail is still unavailable as to how more consistent approaches to restrictive practice can be achieved. As a positive step, the NDIS framework will require NDIS providers with a role in implementing the strategies contained in a behaviour support plan to be certified against additional quality assurance requirements.[9]

Question 7.2: Restrictive practices regulation in NSW

1. ***Should NSW pass legislation that explicitly deals with the use of restrictive practices?***
2. ***If so, should that legislation sit within the* Guardianship Act *or somewhere else?***
3. ***What other forms of regulation or control could be used to deal with the use of restrictive practices?***

The NDIS Framework leaves states and territories responsible for consent and authorisation mechanisms.[10] Therefore, NDS supports the call for restrictive practices legislation in NSW covering these mechanisms with a view to working towards uniformity with other states and territories over time. NDS agrees that the Guardianship Act may not be the appropriate vehicle for regulating restrictive practices since the use of restrictive practices extends beyond guardianship. A specific legislative framework would increase transparency in decision-making about restrictive practices and compliance by providers.

[8] Department of Social Services. *NDIS Quality and Safeguarding Framework*. December 2016 https://www.dss.gov.au/sites/default/files/documents/02_2017/ndis_quality_and_safeguarding_framework_final.pdf at 73

[9] DSS, above n8, at 76

[10] DSS, above n8, at 72

The ACT government are currently conducting consultations about how an Office of the Senior Practitioner (OSP) might operate in the ACT in the absence of any current legislation. Key issues for consideration include whether the OSP should have a role in compliance or only education and support, the nature of any compliance regime and the relationship of such regulation with national disability safeguarding.[11] To further inform the NSW discussion, NDS recommends an inquiry about the potential to enact legislation that explicitly deals with restrictive practice and for an OSP in NSW. We agree that it is necessary to wait for Commonwealth action around the NDIS Framework and legislation before enacting complementary laws in NSW. It is still useful to talk about key elements of any future legislation.

Having discussed restrictive practices regimes in other states with NDS members, NDS supports the Victorian model. In Victoria, there are fewer RPAPs because not all restrictive practices need to go through panels. Having established the unsustainability of RPAPs, we believe in such a system where only high priority/complex cases are brought before a panel. For example, authorisation should be required for serious infringements of a person's rights such as for the administration of medication to children under of 5 or placing locks on the fridge for someone with Prader Willi Syndrome.

Low level issues can be managed by organisations locally and monitored by the Senior Practitioner through a reporting system. Currently clinicians are required to sit on RPAPs, where they complete a large number of checklists and forms, just to authorise restrictive practice of the use of a child lock on transport. This is an example of very low level infringement of someone's rights where reporting rather than an RPAP would be sufficient. NDS also agrees that the authorisation process should depend on what type of restrictive practice is being used and whether it is a short-term or long term response.[12]

[11] JFA Purple Orange, Reducing restrictive practices, A Consultation about the Office of the Senior Practitioner http://www.actosp.org.au/
[12] DSS, above n8 at 73

Such an approach would ensure the best use of service provider's time, especially in the NDIS environment where providers may not have the resources to convene RPAPs for every single restrictive practice in question. One service provider commented that "we're often focussing our energy on less pressing issues when we should be focussing on bigger issues". NDS members recognise that while the proposed regulation of restrictive practices through legislation may represent additional protection for people with disability it may also mean additional oversight and costs for providers of support. NDS believes there needs to be a greater emphasis on monitoring of restrictive practices than on authorisation and this will ease the burden on providers.

Question *7.8* Requirements about the use behaviour support plans

1. ***Should the law include specific requirements about the use of behaviour support plans?***
2. ***If so, what should those requirements be?***

The Senior Practitioner set up under the NDIS Framework is responsible for setting standards and requirements for NDIS providers offering supports to individuals who require a behaviour support plan (BSP).[13] It is therefore expected the Senior Practitioner might be responsible for developing appropriate guidelines for the development, implementation and use of BSP which may be enshrined in federal NDIS Quality and Safeguarding legislation. The NDIS Framework and legislation has not been finalised, therefore potential gaps in behaviour support provision is not fully understood.

Either way, NDS members believe there would be benefits in legislating the requirement for BSPs for persons requiring restrictive practice in NSW. The successful implementation of positive behaviour support strategies can reduce the need for the use of restrictive practices.[14] It is well reported that restrictive practices are used excessively and often in the absence of BSPs.

[13] DSS, above n8 at 73
[14] Australian Psychological Society, above n1 at 19

NDS supports the requirement in Queensland's legislation which requires a clinical assessment of a person to happen before they are subject to restrictive practices. The assessment must be carried out by an 'appropriately qualified person'.[15] Ensuring qualified and skilled behaviour specialists are also involved in designing and helping to implement the BSPs should be outlined within the legislation as well.

Under the NDIS Framework, the Senior Practitioner will be responsible for setting competency standards for behaviour support practitioners.[16] There is concern from NDS members that under the NDIS Framework, the minimum standards set for the qualification of behaviour specialists is very low in comparison to that of ADHC. ADHC behaviour support specialists have been particularly skilled in providing timely clinical support or BSPs for complex participants in NSW requiring behaviour support. Under the NDIS, a recent graduate with as little as two years clinical experience will be deemed "qualified" to operate as a sole practitioner.[17] The shortage[18] of positive behaviour support practitioners is a future challenge for the regulation of restrictive practices in NSW and requires joint monitoring with the NDIS Senior Practitioner.

Question 7.3: Who should be regulated

Who should any NSW regulation of the use of restrictive practices apply to?

In order for any form of regulation to be effective, it is imperative the appropriate parties are regulated. The NDIS framework will not cover mainstream spheres in which restrictive practices are applied to people with a disability (e.g. health, education, aged-care). National, or at the very least NSW, legislation governing restrictive practices should regulate the provision of **all** restrictive practices (not just those within disability services). NDS members have noted that restrictive practices are applied in a range of service settings with varying degrees of appropriateness. For example, our members report that doctors might

[15] Chandler, Willmott and White, above n7 at 26
[16] DSS, above n8, at 74
[17] National Disability Insurance Agency, *NDIS- Registering as a new* provider https://www.ndis.gov.au/providers/nsw-registering-provider.html
[18] DSS, above n8, at 75

use medication or physical restraints in health settings to manage a patients' behaviour without knowing that they constitute restrictive practices.

Similarly, it is common for schools to use strategies that would be considered restrictive practices (exclusionary time out for disruptive children, physically restraining a child etc.) without even knowing it. One reason for this is that unlike the disability sector, Education settings are outside the jurisdiction of policy and oversight relating to restrictive practice.[19] In the 2016 Children and Young People with Disability Survey, rates of restrictive practice were high (with 19% of students with disability surveyed experiencing a form of restraint or seclusion).[20] Legislation covering all these groups will ensure participants will receive consistent support across settings and a commitment to reduce restrictive practices by the people who support them.

Furthermore, NDS recommends the findings of the ACT consultation process around the establishment of an OSP to oversee restrictive practices in education, disability and a range of other contexts should be considered for NSW. The NSW Ombudsman's findings and recommendations regarding the review which is currently underway about positive behaviour support in schools should also be explored to improve regulation in an education context.

Greater education of un-registered disability providers, informal supports (eg. family/carers) and community groups would lead to greater awareness of restrictive practices, the need for their reduction and eventual elimination.

[19] Children and Young People with Disability, *Hear Our Voices, Submission to the Senate Inquiry into the Education of Students with disabilities,* August 2015
[20] Children and Young People with Disability, Education Survey 2016 – National Summary of results, http://www.cyda.org.au/education-survey-2016-national-results

Question 7.7: Safeguards for the use of restrictive practices

What safeguards should be in place to ensure the appropriate use of restrictive practices in NSW?

Monitoring/reporting on the use of restrictive practices is the only way to measure whether strategies for reducing and eliminating the use of restrictive practices are working, and arguably the only way to really reduce and eliminate restrictive practices altogether.[21] ADHC's policy directive currently requires providers to keep internal registers recording the use of some restrictive practice.[22] NDS believes this is insufficient and supports the establishment of an external and independent monitoring mechanism, such as an NSW Senior Practitioner, as a more appropriate safeguard.

The NDIS Senior Practitioner will receive monthly reports on the use of restrictive practices from NDIS providers.[23] It is important for a NSW counterpart to exist alongside it in order to monitor health and education providers and other parties falling outside the scope of the NDIS Framework. NDS stresses the importance of streamlining reporting for NDIS providers so their reporting requirements are not duplicated.

As discussed, legislation itself is also an important safeguard in ensuring better awareness and appropriate use of restrictive practices. Other crucial safeguards include ensuring the use of restrictive practices are subject to independent approval, review and monitoring, and are accompanied by a positive behaviour support approach.

[21] Office of the Public Advocate (Queensland) Systems Advocacy, Response to Discussion Paper Review of the Regulation of Restrictive Practices in the Disability Services Act 2006 and the Guardianship and Administration Act 2000, http://www.justice.qld.gov.au/__data/assets/pdf_file/0016/217402/Review-of-the-Regulation-of-Restrictive-Practices-in-the-Disability-Services-Act-2006-and-the-Guardianship-and-Administration-Act-2000-August-2013.pdf August 2013
Office of the Public Advocate (Queensland) Systems Advocacy, above n21 at
[22] ADHC, above n5, at 23
[23] DSS, above n8, at 77

Question 7.4: Defining restrictive practices

How should restrictive practices be defined?

NDS members support an overarching definition and categorisation of restrictive practices at a federal level. There are a number of benefits for having nationally standardised definitions. First and foremost, to ensure Australia's commitment to United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and other international obligations are upheld. Harmonised definitions of restrictive practices across all settings in which they are applied would standardise regulation and safeguards for people with a disability and other relevant individuals. Having a standard definition will also assist in accurate data collection and research both domestically and internationally. Lastly, a uniform definition will promote consistency between States and Territories which will ensure participants receive consistent support across the country and allow for comparisons to be drawn across different jurisdictions.

The main concern raised in discussion with NDS members was the "clinical drift" that is occurring in relation to the categorisation of restrictive practices outlined in the NDIS Framework. The terms used differ significantly from ADHC's categorisation (which NDS members report is more in line with traditional clinical definitions). The table below compares and contrasts the differences between NDIS and NSW/ADHC definitions:

Table 1: Comparison of terms and definitions

Term		Definition	
ADHC	The NDIS Framework	ADHC	The NDIS Framework
Exclusionary Time Out		Recommendation to deny access to reinforcement by forcibly moving a Service User from one setting to another (e.g. room, corridor) for a period of time under supervision.	

Physical restraint	Physical restraint Mechanical restraint	The recommendation to intentionally restrict a Service User's voluntary movement or behaviour by the use of devices such as lap belts, table tops, posy restraints, bedrails, water chairs, deep chairs or beanbags; physical force; or arm splints	The sustained or prolonged 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 a person's behaviour. The use of a device to prevent, restrict or subdue a person's movement for the primary purpose of influencing their behaviour
Psychotropic Medication on a prn (pro re nata) basis	Chemical restraint	The use of Psychotropic Medication on a prn basis is considered a Restricted Practice. Although the medication must always be administered as prescribed by the medical practitioner, the recommended support strategies are authorised and monitored through the RPA mechanism.	The use of medication or chemical substance for the primary purpose of influencing a person's behaviour or movement. 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 physical condition.
Response cost	Consequence driven practices	The recommendation to withhold positively valued items or activities from a Service User in response to a particular behaviour or set of behaviours (e.g. access to a computer game or TV program).	Usually involve withdrawing activities or items.

Restricted access	Environmental restraint	The recommendation to use physical barriers such as locks or padlocks or impose enforceable limits or boundaries in an environment beyond normally accepted community practices (e.g. keeping hazardous chemicals or cleaning products securely stored)	Restrict a person's free access to all parts of their environment.
Seclusion	Seclusion	The recommendation to isolate an adult Service User (18 years and over) on their own in a setting from which they are unable to leave. This should only be a short-term response to a particular crisis or critical incident in order to manage risk of harm.	The sole confinement of a person with disability in a room or physical space at any hour of the day or night where voluntary exit is prevented, impeded or not facilitated
	Psycho-social restraint		Usually involves the use of 'power-control' strategies.

As noted in Table 1, there are some similarities in the terms and definitions (e.g. seclusion) whilst some definitions are similar the category names are different (e.g. Response cost/ Consequence driven practices). Exclusionary Time Out has been omitted altogether in the NDIS Framework whereas psycho-social restraint has been included. Some of terms are vague (eg. Psycho social and consequence driven practices) and have the potential to lead to misunderstanding.

The changes made in The NDIS Framework will make it difficult for clinicians to find evidence based information in journals that use traditional clinical terms, for example, exclusionary time out. This is concerning as it will impact on the successful implementation

of strategies suggested by behaviour specialists and increase the risk of therapeutic strategies being misused as restrictive practice.[24]

Another point of contention is the definition and regulation of the category "civil detention" and/or "containment". Varying terms are terms used across various states and territories to describe this practice. In some states detention/containment is regulated as a restrictive practice and in others it is regulated through a separate regime as involuntary treatment. The status of civil detention needs to be clarified in any discussion of definitions and needs to be clinically justified.[25]

Question 7.5: When restrictive practices should be permitted?

Australia is a signatory of the UNCRPD and is committed to the reduction and elimination of restrictive practices. Whilst all efforts must be made to seek preventative or alternative measures, there are instances where restrictive practices may be required. Restrictive practices should only be used to protect the rights or safety of the person or others[26]. They should be time limited, subject to review and least restrictive in the circumstances. A behaviour support plan and clinical assessment must be in place. There are some restrictive practices however that should never be sanctioned, and thus should not form part of any regulatory framework. Those include strategies that tend to be punitive in nature, highly subject to misuse or abuse, and those that have little evidence to suggest that they have any long-term efficacy or impact in their use.[27]

[24] Australian Psychological Society, above n1 at 15

[25] Chandler, Willmott and White, above n7 at 101-102

[26] Department of Social Services (2014). *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector (the 'National Framework')*. Australian Government, https://www.dss.gov.au/sites/default/files/documents/04_2014/national_fraemwork_restricitive_practices_0.pdf.

[27] Office of the Public Advocate (Queensland) Systems Advocacy, above n 21, at 6

Question 7.6: Consent and authorisation mechanisms

1. *Who should be able to consent to the use of restrictive practices?*

Restrictive practices require ongoing monitoring and review not just one off consent from a guardian.[28] NDS has concerns about whether private guardians are always best placed to make, what are essentially clinical, decisions about whether a person's behaviour indicates the need for restrictive practices. In addition, private guardians who are most often close family members or friends, could be prone to pressure from service providers to agree to practices for fear of the service relinquishing the care of their family member.[29] Though private guardians make many other decisions that have serious consequences for those subject to guardianship and may bring a degree of independent oversight to the use of restrictive practices, further (and compulsory) training should be required. NDS recommends a broader mandate for the Private Guardian Support Unit in the education of private guardians about consenting to restrictive practices. Ultimately we prefer a joint approach to consent; where the private guardian consents to medical and dental treatment while restrictive practices are consented to by the Public Guardian or NCAT. Alternatively, completely disallowing private guardians to consent to restrictive practices as in Victoria and Tasmania would provide increased safeguards.[30]

2. *What factors should a decision-maker have to consider before authorising a restrictive practice?*

A lengthy discussion of this question can be found in response to question 7.2. One additional point we wish to make is that there ought to be shift to the requirement that substitute decision-makers have regard to the will, preferences and rights of the person with impaired decision-making ability[31], rather than applying the current best-interests test.

[28] Chandler, Willmott and White, above n7 at 121
[29] Chandler, Willmott and White, above n7 at 120
[30] NSW Law Reform Commission, Consent to Medical and Dental Treatment Question Paper 5, p 52 at 7.37 http://www.lawreform.justice.nsw.gov.au/Pages/lrc/lrc_current_projects/Guardianship/Question-Paper-5.aspx
[31] Australian Law Reform Commission, above n4

3. *What should be the mechanism for authorising restrictive practices in urgent situations?*

As previously discussed, there are future challenges regarding the authorisation of restrictive practices via RPAPs, especially at short notice. The requirement for authorisation should depend on the nature and seriousness of the restrictive practice in question and whether reporting would be sufficient (discussed in response to question 7.2). Therefore, this question also relates to how restrictive practices should be *reported* in urgent situations. We are aware that many stakeholders agree that there should be mandatory reporting of the emergency use of restrictive practices and one-off reporting where a support plan includes a restrictive practice.[32]

Consent should always be sought where practicable. While the preference is to seek consent from the person or guardian, RPAPs have been an effective source of consent to urgent restrictive practices. Where there is a public guardian appointed, NCAT duty guardians should be utilised as far as possible as they can provide consent quickly over the phone.

What changes, if any, should be made to NSW's consent and authorisation mechanisms for the use of restrictive practices?

A summary of NDS's recommendations made throughout this paper are summarised here

Specific Legislation addressing restrictive practices

- NDS recommends an inquiry about the potential to enact legislation that explicitly deals with restrictive practice and for an OSP in NSW.
- Legislation must occur across settings including mainstream interfaces such as health and education, there is potential for it to apply to private individuals as well
- More education on the prevention and use of restrictive practices needs to be available, particularly for families and the informal supports and sectors uch as education

[32] JPA Purple Orange, above n2, at 13

- People with a disability should also be aware of, and be supported to access, sources of independent advice and advocacy
- There ought to be shift to the requirement that substitute decision-makers have regard to the will, preferences and rights of the person with impaired decision-making ability, rather than applying the current best-interests test.

Alternatives to authorisation and need for reporting

- Restrictive Practice Panels should only oversee high priority/complex cases. Lower priority or low level practices could use a reporting mechanism
- NDS believes in a greater emphasis on monitoring of restrictive practices than on authorisation. The authorisation process should depend on what type of restrictive practice is being used and whether it is a short-term or long term response
- Establishment of an external and independent monitoring mechanism, such as an NSW Senior Practitioner (however, ensuring that NDIS providers reporting requirements are not duplicated under such a model)
- Mandatory reporting of emergency use of restrictive practices and of one-off reporting where a support plan includes a restrictive practice should be explored

Behaviour Support plans and practitioners

- The use of behaviour support plans for persons requiring restrictive practices should also be legislated
- The minimum qualifications and experience for practitioners delivering behaviour support needs reviewing/monitoring as well as supply and demand issues
- Adequate funding for behaviour support needs to be addressed urgently.

Definitions

- Defining legislation at a Commonwealth level should occur and apply across a range of settings. The terms used within the definition need reviewing in line with traditional clinical terminology
- The status of civil detention needs to be clarified in any discussion of definitions and needs to be clinically justified

Private Guardians

- NDS recommends a wider reach of the Private Guardian Support Unit in the education of private guardians about consenting to restrictive practices. Alternatively, a stricter approach to private guardians consenting to restrictive practices should be considered
- NDS prefers a joint approach to consent; where the private guardian consents to medical and dental treatment while restrictive practices are consented to by the Public Guardian or NCAT.
- Restrictive practices require ongoing monitoring and review not just one off consent from guardians