

Submission to the NDIS Evidence Advisory Committee Consultation February 2026 on Positive Behaviour Support for Participants with Psychosocial Disability

Consumers of Mental Health WA

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1. Acknowledgement of Country

Consumers of Mental Health WA proudly acknowledge Aboriginal people as Australia's First Peoples and the Traditional Owners and Custodians of the Land and Water on which we live and work. We acknowledge Western Australia's First Nation's communities and culture and pay respect to Aboriginal Elders past, present and emerging.

We recognise that Sovereignty was never ceded and the significant and negative consequences of colonisation and dispossession on Aboriginal communities.

Despite the far-reaching and long-lasting impacts of colonisation on First Nations communities, Aboriginal people remain resilient and continue to retain a strong connection to culture. We acknowledge the strong connection of First Nations Peoples to Country, culture and community, and the centrality of this to positive mental health and wellbeing.

2. Preamble

2.1 About the Respondents

Consumers of Mental Health WA (CoMHWA) is Western Australia's peak body for and by mental health consumers (people with a past or present lived experience of mental health issues, psychological or emotional distress). We are a not-for-profit, systemic advocacy organisation independent from mental health services that exists to listen to, understand and act upon the voices of consumers. We work collaboratively with other user-led organisations and a diversity of stakeholders to advance our rights, equality, recovery and wellbeing.

2.2 Request for Feedback

CoMHWA works to uphold the dignity and human rights of consumers, through providing advocacy in leading change with and for consumers. We appreciate notification of the outcomes of our submission to this consultation in order to understand and communicate the difference made through our work.

Please provide feedback via the contact details on this submission's cover page.

2.3 Language

CoMHWA uses the term mental health 'consumer' throughout this submission. Mental health consumers refer to people who identify as having a past or present lived experience of psychological and emotional distress, irrespective of whether they have received a diagnosis of mental illness or accessed services. Other ways people may choose to describe themselves include "peer", "survivor", "person with a lived experience" and "expert by experience".

This definition is based on consumers' call for respect, dignity and choice in how we choose to individually identify. As individuals we choose different ways to name and describe our experiences that may confirm or trouble ideas about 'mental illness'.

CoMHWA endorses the Indigenous Australian Lived Experience Centre's (IALEC) [universal definition](#) of lived experience for First Nation communities:

A lived experience recognises the effects of ongoing negative historical impacts and or specific events on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. It encompasses the cultural, spiritual, physical, emotional and mental wellbeing of the individual, family or community.

People with lived or living experience of suicide are those who have experienced suicidal thoughts, survived a suicide attempt, cared for someone through a suicidal crisis, been bereaved by suicide or having a loved

one who has died by suicide, acknowledging that this experience is significantly different and takes into consideration Aboriginal and Torres Strait Islander peoples' ways of understanding social and emotional wellbeing.

This definition recognises that there are fundamental differences to how Aboriginal and Torres Strait Islander people experience and define mental health challenges and suicide compared to mainstream definitions.

2.4 About the consultation

Reproduced from the Australian Government Department of Health, Disability and Ageing consultation [webpage](#).

“The NDIS Evidence Advisory Committee (EAC) was established in an ongoing capacity by the Australian Government in response to the NDIS Review. The EAC will make recommendations to government on the safety, suitability and value for money of supports for NDIS funding, drawing on the best available evidence.

[...]

This consultation is about the next group of supports to be considered by the EAC:

- Early intensive behavioural interventions
- Positive behaviour support for older children and adults
- Robot-assisted gait training
- Social skills training as a disability support for children and young people.”

Input was invited through a variety of modes including written submission to disabilityevidence@health.gov.au, and consultation was open until 29th March 2026.

3. Introduction

CoMHWA welcomes the opportunity to provide feedback to the NDIS Evidence Advisory Committee Consultation February 2026. As the peak body in WA for mental health consumers, we focus in this submission on providing feedback informed by the experiences of consumers and of NDIS participants with psychosocial disability, in the hopes that this will provide insight into which supports can meet the needs of a group of NDIS participants whose independence and recovery, the NDIS Review made clear, have not in the past been adequately supported in the Scheme.¹ We limit our submission to discussion of positive behaviour support for adults.

CoMHWA has heard from participants with psychosocial disability who have positive behaviour support that many of their experiences with this type of support have been poor, to the point of causing harm. There are significant barriers that prevent positive behaviour support from enabling the kind of outcomes for participants that it was designed to achieve, notably around supporting the reduction and elimination of restrictive practices. This is of particular concern to CoMHWA, as restrictive practices cause harm, undermine human rights, have no therapeutic benefit, and so it is our position that these must be eliminated.² CoMHWA hears that planned 'phase outs' of restrictive practices are rarely actioned, and that positive behaviour support in the NDIS, as the very mechanism through which use of restrictive practices is authorised, is also what is perpetuating their ongoing use. CoMHWA feels that the NDIS Commission must take urgent and significant action to eliminate restrictive practices, acknowledging that the current approach and supports that are designed to do this are not working as intended. There is some research evidence, and some participant lived experience accounts that suggest positive behaviour support can enable positive outcomes for some participants with psychosocial disability. Yet, to leverage the potential of this support, urgent work is required to build a competent workforce of behaviour support practitioners, ensure the quality of behaviour support plans, oversee, resource, monitor and ensure implementation of plans, and take action to prevent harm. Restrictive practices should be eliminated from the NDIS, not perpetuated through positive behaviour support.

We base our submission on:

¹ NDIS Review, Commonwealth of Australia, Department of the Prime Minister and Cabinet. (2023). *Working together to deliver the NDIS Independent Review into the National Disability Insurance Scheme: Final report*. <https://www.ndisreview.gov.au/sites/default/files/resource/download/working-together-ndis-review-final-report.pdf>, p. 129.

² Consumers of Mental Health WA. (2025). *CoMHWA Position Paper: Restrictive Practices*. <https://comhwa.org.au/wp-content/uploads/2025/11/SA-2025-Position-Paper-1-Restrictive-Practice.pdf>

- One to one discussions with consumers who are accessing NDIS for psychosocial disability supports, or who are in the process of seeking NDIS access
- Ongoing consultation with CoMHWA’s consumer reference and advisory groups, including our NDIS reference group that is comprised of NDIS participants with psychosocial disability.
- Ongoing data collection and input from CoMHWA’s Individual Advocacy and Peer Pathways (service navigation) programs.
- Ongoing consultation with consumers in Western Australia on joint priorities for an improved mental health system
- Consumer representation in relevant settings, including but not limited to: Primary Health networks (WAPHA), WA regional equivalents of the Local Health Networks (regional mental health services under the WA Health Board structure), the Mental Health Commission and the health complaints agency, Health and Disability Services Complaints Office (HaDSCO).

CoMHWA provides feedback focusing on the experiences of participants with psychosocial disability with positive behaviour support, exploring impacts, harms and outcomes, who should provide this support, and alternative options that can meet participants’ needs, addressing where relevant questions the Evidence Advisory Committee (EAC) asks in its consultation survey throughout our submission.

4. Discussion

4.1 Positive behaviour support for people with psychosocial disability

Participants with psychosocial disability may have positive behaviour support on their NDIS support plans, but we heard from participants that they were not given clear information on, or supported to develop a strong understanding of, what positive behaviour support entails. As such, they did not know what to expect regarding what outcomes they can experience, or what good quality support looks like. One participant told CoMHWA that because she did not understand the behaviour support practitioner role and what good support looks like, she had very poor experiences that she did not realise were not the norm or were not good practice. Participants must be given information and supported to understand this type of support so that they are able to make informed decisions about what support they want to access, what will support their own wellbeing, and exercise choice and control. This understanding is also an important safeguard, as it helps participants to recognise potential issues in their supports earlier on. Such understanding is also essential for participation involvement in creation of support plans. In particular, restrictive practices plans are meant to be created with participants, but we heard accounts that this was not consistent, or even common, practice.

4.2 Harms of restrictive practices and positive behaviour support in the NDIS

Positive behaviour support often includes use of restrictive practices, and positive behaviour support is sometimes put in a person's plan explicitly to enable the use of regulated restrictive practices. This use of restrictive practices is causing harm, and so positive behaviour support in the NDIS is resulting in:

- Denial of dignity of risk. Restrictive practices can be used to prevent participants making choices that other people are free to make, such as preventing participants from purchasing cigarettes, soft drinks, or other goods and services that workers deem unhealthy. Positive behaviour support ought to play a role in supporting dignity of risk rather than foreclosing it due to risk aversion.
- Facilitating ongoing use of restrictive practices in the NDIS rather than enabling the reduction and elimination of restrictive practices. One participant told us of the ongoing use of regulated restrictive practices against them, which caused continuous harm. This included environmental restriction, as she would be locked within her own home by support workers, as well as restrictions in access to medications and sharps. Instead of preventing self-injury, which was the ostensible reason for the restriction, the participant said that because she was never supported to develop other behaviours, including the behaviours and ways of thinking that would better support her wellbeing, these restrictive practices resulted in more harm. She was not supported with building behaviours, capabilities or responses that would enable her to be around sharps, medications, and other such items safely, and recounted that this became a major issue when in environments that were unfamiliar or where those items were in the open.
- Removal of participant choice and control, autonomy and independence. We have heard of restrictive practices plans, that, despite guidelines around these, have not been created with participants and contain incorrect information or a mistaken views about needs, and remove choice and control in denying participants a say in their supports.

Barriers to positive behaviour support eliminating restrictive practices in the NDIS

Many of the barriers to positive behaviour support in the NDIS being able to reduce and eliminate use of restrictive practices have been identified within existing research; these include: "reluctance on part of stakeholders, difficulties implementing PBS, a lack of data on the use of restrictive practices, and challenges

communicating and collaborating with other team members.”³ Another recent study noted further barriers, including: “the need for access to quality training and clinical supervision, and barriers relating to inadequate and inconsistent funding in the context of resource-heavy compliance activities.”⁴

The participants and stakeholders to whom CoMHWA has spoken to have noted that those barriers are ongoing, and that further barriers include:

- Failure to action planned ‘fade outs’ for use of restrictive practices, which are meant to be built into every individualised behaviour support plan. As a result, restrictive practices are used in an ongoing and long-term way, and participants often have positive behaviour support on their plans in an ongoing manner explicitly to enable the use of restrictive practices. Safeguards are not working to identify and prevent the harms of the use of restrictive practices, and ensure that fade-out plans are observed.
- Decision-making about use of restrictive practices rests, many times, on the limited capacity, availability, and lack of training, experience and skills of support workers. For example, workers not being available to accompany a participant to a shop or for a walk outside, and so deciding to put environmental restrictions in place to prevent a participant from leaving their house.
- Poor quality positive behaviour support plans that do not support good practice implementation of positive behaviour support and can lead to harm. This is reinforced by literature that shows a high prevalence of poor-quality behaviour support plans in Australia,⁵ and in the NDIS.⁶
- Financial motivations of many providers, which undermine good practice, as positive behaviour support is a higher-paid support type than some others in the NDIS.
- Compliance frameworks that do not encourage genuine good practice. Research examining Australian policy requirements with respect to positive behaviour support practice has shown that these are not aligned with high quality practice and that these policies have become “informal rules

³ Leif, E. S., Fox, R. A., Subban, P., & Sharma, U. (2023). ‘Stakeholders are almost always resistant’: Australian behaviour support practitioners’ perceptions of the barriers and enablers to reducing restrictive practices. *International Journal of Developmental Disabilities*, 69(1), 66–82. <https://doi.org/10.1080/20473869.2022.2116908>

⁴ Fisher, A., Louise, K., Reschke, K., Kremer, P. & Kelly, G. (2024). Positive behaviour support under the National Disability Insurance Scheme in Australia: Barriers, enablers and support needs from the perspective of practitioners. *Australian Journal of Social Issues*, 59, 1031–1049. <https://doi.org/10.1002/ajs4.316>

⁵ Wardale, S., Davis, F., Vassos, M., & Nankervis, K. (2018). The outcome of a statewide audit of the quality of positive behaviour support plans. *Journal of Intellectual & Developmental Disability*, 43(2), 202–212. <https://doi.org/10.3109/13668250.2016.1254736>

⁶ National Disability Insurance Scheme Quality and Safeguards Commission. (2022). *Behaviour support plan quality: Summary results to December 2021*. <https://www.ndiscommission.gov.au/sites/default/files/2022-10/Behaviour%20Support%20Plan%20Quality%20Public%20Paper.pdf>

for using restrictive practices, not reducing them.”⁷ Current frameworks for legislative compliance can function as a barrier for good practice.⁸

Positive behaviour support, as one study highlights, are limited by the framework within which support is funded in the NDIS, taking an individual-level, reactive view in response to what are thought of as “challenging behaviours,” an approach that “neglects the importance of building effective systems that could prevent challenging behaviours in the first place (e.g., where they are a response to unmet needs).”⁹ The framing of behaviours as challenging, problematic, or threatening can itself be an outcome of mental health stigma, which often perpetuates the myth that people with mental health challenges are dangerous,¹⁰ ignoring the contexts in which mental distress and behaviours occur.¹¹

The interaction between NDIS, approaches to restrictive practices, Guardianship and Administration legislation, and mental health legislation presents serious challenges for participants having choice, control, full enjoyment of their human rights, and autonomy. The NDIS has driven increases in guardianship orders,¹² and guardians may be involved in decision-making about restrictive practices in relation to persons who have been judged as not having decision-making capacity by registered NDIS service providers.

As research from the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability explains, there are serious conceptual and practical issues inherent in assumption that transforming unauthorised restrictive practices into authorised restrictive practices will be an effective mechanism for ending restrictive practices.¹³ Recent data on both authorised and unauthorised restrictive practices notifications in the NDIS shows that proportion of participants being subject to authorised

⁷ Hayward, B. A., McKay-Brown, L., & Poed, S. (2023). Restrictive Practices and the ‘Need’ for Positive Behaviour Support (PBS): A Critical Discourse Examination of Disability Policy Beliefs. *Journal of Intellectual Disabilities*, 27(1), 170-189.

<https://journals.sagepub.com/doi/10.1177/17446295211062383>

⁸ Carberry, T., Wardale, S., Hutchison, S., Lackey, S., & Vassos, M. (2024). Positive Behaviour Support is effective when implemented correctly: a response to “Restrictive practice – A pathway to elimination” (Spivakovsky, Steele, & Wadiwel, 2023). *Research and Practice in Intellectual and Developmental Disabilities*, 11(2), 251–264. <https://doi.org/10.1080/23297018.2024.2391804>

⁹ Fisher et al., 2024.

¹⁰ Gill, N., Tezak, T., Evans, M., & Gooding, P. (2024). Coercion in Psychiatry and Mental Health Care: Ethical, Legal, and Human Rights Considerations. *World Social Psychiatry*, 6(3), 112–116. https://doi.org/10.4103/wsp.wsp_21_24

¹¹ Elwyn, R., Clarke, K.-A. & Jones, C. (2025). Narrative Review and Meta-Ethnography of Seclusion and Restraint from the Perspectives of Adults with Lived Experience: A Human Rights Issue and Application to Australian Context. *Australian Journal of Social Issues*, 1–14. <https://doi.org/10.1002/ajs4.70082>

¹² Law Reform Commission of Western Australia. (2026). *Project 114 – Guardianship and Administration*. <https://www.wa.gov.au/government/publications/project-114-guardianship-and-administration>

¹³ Spivakovsky, C., Steele, L., & Wadiwel, D. (2023). *Restrictive practices: A pathway to elimination*. Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. <https://disability.royalcommission.gov.au/publications/restrictive-practices-pathway-elimination>

regulated restrictive practices, and overall proportion experiencing unauthorised restrictive practices have remained similar over time.¹⁴ The overall rate of participants experiencing unauthorised restrictive practices is not meaningfully declining over time.¹⁵

4.3 Positive outcomes from positive behaviour support

CoMHWA has heard that positive behaviour support can result in good outcomes for consumers, when provided by a capable and experienced practitioner. When positive behaviour support is done well, it can support reduction and elimination of restrictive practices, as one participant we spoke to has experienced. That participant explained that they are now living independently, and are better able to make decisions, participate in their own supports, and have more choice and control in their life:

“It changed my life having [specific behaviour support practitioner] and it would have ruined my life if she hadn’t come on.”

Stronger oversight of outcomes from positive behaviour support is needed to understand whether it is achieving the outcomes intended.

4.4 The need for capable, experienced, qualified practitioners

CoMHWA feels that positive behaviour support should be provided by qualified, capable, experienced practitioners with expertise working with people with psychosocial disability or mental health challenges. CoMHWA heard from participants that the personal qualities, approach, values and communication style of individual positive behaviour support workers made a significant difference to the quality of the support. These included ability to build trust, degree of openness, alongside honesty and transparency in communication around ways of working. A participatory approach that responds to and keeps the participant centred and involved with process and support is a part of good practice. One example we heard of was a behaviour support practitioner actively involving participants in training provided to support workers in the participant’s support team, which the participant felt enabled that training to be more tailored what she needs, and meant that she was part of the upskilling and discussions among the team about how best to work with and support her. The behaviour support practitioner has enabled a reduction

¹⁴ NDIS Quality and Safeguards Commission. (2026). *Quarterly Performance Report: Q2 2025-26*. Accessed from: <https://www.ndis.gov.au/publications/quarterly-reports>, pp. 21-23.

¹⁵ Productivity Commission. (2026). Figure 15.8c Measure 2b: Unauthorised use of restrictive practices (all modes) in: 15 Services for people with disability, *Report on Government Services 2026*. <https://www.pc.gov.au/ongoing/report-on-government-services/community-services/services-for-people-with-disability/>

in support workers calling emergency services and has engaged with local emergency services workers to facilitate better support across service systems. In her words:

“When you find someone that works with you rather than against you or for you it’s good. We work for same goals.”

Another positive quality is practitioners capable of and committed to upskilling and training people in a participant’s support team to work in appropriate ways.

CoMHWA hears from participants and sector stakeholders that despite regulatory requirements and processes put into place by the NDIS, positive behaviour support is often provided by individuals without appropriate qualifications, training or experience. It is possible for a person with little to no specific experience, training or qualifications to apply to become a behaviour support practitioner within the NDIS, especially if they are already a registered provider or are engaged by a registered provider, and especially through the entry-level pathway. PBS is a higher paid support in the NDIS, meaning there is a financial incentive to become a NDIS-approved PBS practitioner and for providers to encourage staff to become PBS practitioners. On the one hand, this does support numbers of positive behaviour support practitioners in the NDIS and therefore participant access to these supports, but on the other, it comes with a requirement for the appropriate oversight to ensure that practitioners are skilled and capable, and promote the human rights of participants. One participant told us that she had experiences with four behaviour support practitioners, and only one of these has been helpful rather than actively harmful, and has supported the participant to live a more independent life, participate in the community and develop the behaviours that support her own wellbeing goals. CoMHWA believes that participants should not have to go through so many poor experiences before finding the right provider, and that engaging the right provider should not be a matter of chance.

Given the lived experience that participants have shared with CoMHWA regarding their experiences with this kind of support, there is a lack of appropriate oversight, something that is further confirmed by a recent audit of the NDIS commission, which showed that it is only partly fulfilling its regulatory role. Particular areas of weakness identified include that it lacks a regulatory risk framework to guide decision making and that it does not have a risk-responsive or proportionate system for monitoring, compliance and enforcement activities, and has no way to assess the effectiveness of its activities to detect and address non-compliance.¹⁶ The NDIS Commission is working on ways to address issues identified in the audit report,

¹⁶ Australian National Audit Office. (2025). *Effectiveness of the NDIS Quality and Safeguards*

Commission’s Regulatory Function. <https://www.anao.gov.au/work/performance-audit/effectiveness-the-ndis-quality-and-safeguards-commissions-regulatory-functions-2025>, pp 8-9.

and its most recent annual report noted that “an Independent review of the Positive Behaviour Support Capability Framework and NDIS practitioner suitability assessment process recommended stronger education requirements and oversight” and noted that a five-year roadmap is being developed in 2025-26 to address this.¹⁷

4.5 Alternative Supports

NDIS participants have told CoMHWA of what they would like to access as support options in the NDIS that could best meet needs related to psychosocial disability or mental health challenges. Some of those supports could address similar needs as positive behaviour support, and would be more aligned with participants’ own understandings and experiences of what is helpful and supportive for them. These include:

- Psychosocial recovery supports, coaching, and peer support, for participants with psychosocial disability. These could provide recovery-oriented support and assist with skill development, community participation, independence, and wellbeing support, without use of restrictive practices.
- Mainstream devices and appliances, apps, smart devices and appliances and sensory aids or supports. Some of these are technically accessible through the NDIS but that participants with psychosocial disability have found exceedingly difficult or impossible to access. Ensuring that participants with psychosocial disability have funding to access such supports is essential. CoMHWA has heard that being unable to access supports that assist to navigate community spaces and to live safely in their home can mean it is difficult to access support to self-regulate and de-escalate in some situations (where having noise-cancelling headphones, for instance, would help), and undermine ability to live independently.
- Funding to support ability to make adjustments to living space, and support with communication if needed. These can meet some of the needs behaviour supports currently attempt to address.
- Therapeutic supports. These can enable more participants to build skills, behaviours and support wellbeing and ability to engage and participate in the community. Participants report that changes within the NDIS have made access to these kinds of supports more challenging.

¹⁷ NDIS Quality and Safeguards Commission. (2025). Annual Report 2024-25. <https://www.ndiscommission.gov.au/sites/default/files/2025-11/NDIS-Commission-Annual-Report-2024-25.pdf>, p. 31.

It is clear that change is needed within the NDIS to eliminate restrictive practices. Lived experience expertise is a valuable resource for this work,¹⁸ and a could inform a program of consumer co-designed NDIS provider workforce training and capacity building across skillsets and areas of knowledge including de-escalation, how people in distress communicate, trauma-informed care, human rights, and supported decision-making.

5. Conclusion

CoMHWA has heard that, when provided by a capable practitioner, positive behaviour support can enable capacity building, independence, choice and control, while also ensuring freedom from restrictive practices. However, based on their experiences to this date, participants were not able to trust that they would experience positive outcomes with many behaviour support practitioners in the NDIS as it is currently structured. Positive behaviour support has the potential to enable good outcomes, but the way positive behaviour support is presently defined, governed, provided and practiced in the NDIS, is leading to harms and to poor outcomes for many participants, and is not reducing or eliminating restrictive practices. CoMHWA feels that positive behaviour support in the NDIS must be transformed so that restrictive practices are eliminated. Restrictive practices have no place in a Scheme that aims to improve the choice, control, independence, rights and autonomy of people with disability.

¹⁸ Bennetts, S. L., Pepin, G., Moylan, S., Carolin, R., Forrester-Bowling, T., McLure, J., Brown, A. D., & Lucas, J. J. (2024). Co-designing restrictive practice elimination: A systems thinking approach with mental health service users and practitioners in rural/regional Australia. *International journal of mental health nursing*, 33(5), 1564–1574. <https://doi.org/10.1111/inm.13352>

Elwyn at al., 2025.



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