Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2024

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Dear Committee Secretary

Submission on the Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2024

This submission is made by Associate Professor Dinesh Wadiwel and Associate Professor Linda Steele.

We are co-authors along with our colleague Dr Claire Spivakovsky (University of Melbourne) of *Restrictive Practices: A Pathway to Elimination*. This research report was commissioned by the Royal Commission into Violence, Abuse, Neglect and Exploitation and published by the Royal Commission in 2023. It was produced with the guidance of an expert advisory group of representatives from Australian Disabled People's Organisations and is informed by published accounts of disabled people's lived experiences of restrictive practices. On 6 November 2023, Dr Spivakovsky and Associate Professor Steele presented our key findings to relevant Queensland Government officers working on restrictive practices related matters.

We are writing to formally submit our research report to the Community Support and Services Committee on the basis it provides an evidence-based and human rights framework for eliminating restrictive practices which could inform Queensland's legislative reform. We note that our report contains an eight-point plan for the elimination of restrictive practices that will also deliver justice and equality to people with disability who experience their use.

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Sincere Regards,

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

Research **Report**

Restrictive practices: A pathway to elimination

The University of Melbourne
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Executive summary

Purpose of the research

This report provides guidance to the Disability Royal Commission in relation to the Commission's objective to reduce and eliminate restrictive practices. Restrictive practices are at odds with the human rights of people with disability and represent a significant form of violence and coercion. The following definition of restrictive practices has been devised by the authors of the report based on the findings presented in the report, and is for use in the report and elsewhere:

Restrictive practices are legally authorised and/or socially and professionally sanctioned violence that targets people with disability on a discriminatory basis and are at odds with the human rights of people with disability. Restrictive practices include, but are not limited to, chemical, mechanical, physical and environmental restraint and seclusion, guardianship, forced sterilisation, menstrual suppression and anti-libidinal medication, financial management, involuntary mental health treatment, and other non-consensual or coercive interventions said to be undertaken for protective, behavioural or medical reasons.

Scope: Objectives and research questions

The Disability Royal Commission set five core objectives for the research project:

1. To identify and analyse systemic drivers of the use of restrictive practices across settings across Australia.
2. To identify and analyse strategies to reduce and/or eliminate the use of restrictive practices and exclusion.
3. To examine whether the existing findings of the Royal Commission in relation to positive behaviour support generalise in relation to other types of restrictive practices and disabilities. Here we note that Public Hearing 6 did not provide sufficient evidence to determine why positive behaviour support may be viewed by some as a best practice response to perceived 'behaviours of concern', nor if positive behaviour support is effective in reducing the full range of restrictive practices used against all people with disability.
4. To undertake this research in alignment with the Terms of Reference of the Royal Commission.
5. To inform the Royal Commission's policy development, identification of possible solutions, and recommendations for its final report.

The Disability Royal Commission set the following research questions for the research project:

RQ1: What are the systemic drivers of the use of restrictive practices against people with disability? How do these differ across settings across Australia?

RQ2: What measures and strategies are most effective in addressing these drivers and reducing or eliminating the use of restrictive practices against people with disability?

Does this differ by setting, or by the type of restrictive practice? What measures have been proven ineffective in addressing restrictive practices?

RQ3: Is positive behaviour support effective in reducing and eliminating the use of restrictive practices? Is it more effective in relation to certain types of disabilities, certain restrictive practices, or certain settings?

RQ4: Are there local and international models of policies and practices that have resulted in effective reduction in the use of restrictive practices?

Methodology

The research project adopted a disability human rights methodology. The project included elements that were both participatory and emancipatory: involving representatives from Disabled Peoples Organisations in all phases of the project and seeking explicitly to arrive at conclusions that realise the rights of people with disability. Data collection and analysis was undertaken in three, connected parts:

1. **Centring the experiences and rights of people with disability.** The project centred the experiences and rights of people with disability. A review of relevant scholarly literature, reports and submissions containing secondary empirical data was conducted to capture lived experiences of people with disability subject to restrictive practices. As described below, due to time constraints, it was not possible to conduct a new empirical study of these experiences.
2. **Expert Reference Group.** An Expert Reference Group comprising representatives from Disabled Peoples Organisations in Australia was established for the project. The reference group met six times over the life of the project and ensured the disability community had ownership of, and provided guidance on, all phases of the research project.
3. **Review of academic and grey literature.** To ensure inclusion of both multidisciplinary scholarship, as well as scholarship incorporating diverse research designs – including qualitative, quantitative, and mixed-method approaches – the research team sourced the academic and grey literature from:
    a. The leading generalist research databases, including EBSCO, Scopus, and ProQuest.
    b. Specialist research databases, such as ERIC (educational settings research), HeinOnline (legal research), and PsycINFO (behavioural and social science research).

Limitations

The research team were provided with nine-months to complete the research project. Within this timeframe, it was not possible to conduct a new empirical study of the experiences of people with disability who have been subject to restrictive practices. Such studies require substantial time and planning, particularly to ensure ethical considerations are adequately addressed. The report instead drew on secondary empirical data about people with disability's experiences of restrictive practices collected from scholarly literature, reports and government inquiries.

Contemporary research into use of restrictive practices is marked by several limitations. These limitations shape the scope and limits of this report. There has been little scholarly research into the experiences of people with disability subject to restrictive practices in Australia. For this reason, the report includes experiences of people with disability who live in other, comparable countries. There has also been little to no research into the specific experiences of restrictive practices for LGBTQIA+ people with disability, or culturally and linguistically diverse people with disability. Only a few studies consider the experiences of First Nations people with disability. Additionally, while people with disability's experiences of some forms of restrictive practices are well explored – such as experiences of seclusion or involuntary mental health treatment – experiences of other forms of restrictive practice such as guardianship or financial management are rarely considered. This disparity in accounts is at least in part reflective of the opportunities that have and have not been provided to people with different types of disability to articulate experiences of restrictive practices over the years. Very few researchers venture into group homes to speak with people with disability, and, to the best of our knowledge, little to no attempts have been made to capture the accounts of people with disability subject to restrictive practices in the context of Australian Disability Enterprises, day programs, out-of-home-care, immigration detention, and in the family home. Each of these limitations within contemporary scholarship impact the ability of this report to respond with strong specificity in relation to relevant research questions set by the Disability Royal Commission about observed differences between types of disability, types of restrictive practice and/or types of setting. Further research will be required to address these areas of interest for the Disability Royal Commission.

Finally, there are also limitations inherent to contemporary research concerning strategies and approaches to reducing or eliminating restrictive practices. While there are a range of 'high-level' frameworks and principles for reducing and/or eliminating restrictive practices outlined for implementation in Australia across a range of different settings, including mental health settings, disability services settings and educational settings, there has been little to no research conducted to date on the effectiveness of these approaches. Moreover, where the question of effectiveness has been considered internationally, this has almost exclusively occurred in the context of mental health settings alone. Again, these limitations within contemporary scholarship on strategies for reducing and/or eliminating restrictive practices impact the ability of the report to respond with strong specificity in relation to relevant research questions set by the Disability Royal Commission about observed differences in effect between

different types of approaches, types of disability, types of restrictive practice and/or types of setting. Further research will also be required to address these areas of interest for the Disability Royal Commission.

Findings

Finding One: Restrictive practices are at odds with international human rights obligations

Use of restrictive practices is at odds with international human rights obligations for the treatment of people with disability. There is an absolute non-derogable prohibition on torture and cruel, inhuman or degrading treatment or punishment under international law. This means that restrictive practices that rise to the level of torture and cruel, inhuman or degrading treatment or punishment must be prohibited. Further, there are strong human rights obligations relating to prohibition of discrimination against people with disability and rights to protection from violence. In so far as restrictive practices represent a form of violence that is applied on a discriminatory basis to people with disability, then these practices, even where they do not rise to the level of torture and cruel, inhuman or degrading treatment or punishment, are at odds with international law.

Finding Two: Restrictive practices strip people with disability of dignity

The principle of dignity is at the core of international human rights obligations to prevent torture and ill-treatment, protections from violence, and equality and non-discrimination. Use of restrictive practices fails to respect the inherent dignity of people with disability. Analysis of the lived experiences accounts we collected shows that people with disability experience restrictive practices in the following, interconnected ways:

1. **Trauma, pain, harm and violation.** The report includes numerous accounts of people with disability speaking about their experiences of restrictive practices as physically painful, psychologically harmful and as a violation. For some people with disability, the trauma of restrictive practices intersects with, and is at times compounded by, other dynamics of oppression and injustice, such as settler colonialism and gender-based violence.
2. **Abandonment and neglect.** The report provides numerous examples of people with disability who were either left alone in seclusion without any supervision, or who had their experiences of distress and harm from restrictive practices ignored. The resulting effect of these experiences was people with disability feeling abandoned by those tasked with supporting them, and in turn helpless to improve their circumstances.

3. **Fear.** Based on accounts examined in this report, many people who are subject to seclusion describe their experience of this as frightening. For some people with disability, this fear manifests from the brutality of their experience of seclusion and restraint itself, or from their experiences of abandonment. For others, the fear comes from a sense of not knowing what will happen next, and, importantly, not feeling safe enough in the setting to believe that what could happen next would be anything other than more harm.

4. **Disempowering, humiliating and dehumanising.** The report provides several examples of people with disability speaking directly to feelings of powerlessness in the context of restrictive practices. Some people with disability speak about powerlessness in terms of losing all control and having everything taken away. Others describe their experiences of powerlessness as amounting to a broader humiliation. Finally, some people with disability speak about their experiences of restrictive practices in terms of dehumanisation.

5. **Cruel and punishing treatment.** There are many examples in the report of people with disability describing being subject to restrictive practices who experience these as cruel a nd/or as punishment. Some people with disability are put in cages or are subject to experiences that make them feel as if they are being 'caged' and 'treated like an animal'. Several accounts provided in the report express a common rationalisation among some people with disability subject to restrictive practices: that 'I must have done something really wrong' to be punished with this form of treatment.'

6. **Lifelong trauma and life-altering effects.** Based on the accounts surveyed in this report, for some people with disability restrictive practices can have life-altering effects and contribute to lifelong trauma. Restrictive practices also fundamentally change how a person with disability may understand themselves and locate future meaning in their life.

Finding Three: Restrictive practice occur within an ecological system of violence, coercion and control

Restrictive practices take shape in an ecological system of violence, coercion and control. This ecological system extends out from individual people with disability, enveloping the person in concentric circles of relationships, institutions and social structures. The drivers and enabler of restrictive practices are located within this ecological system. The figure below illustrates the ecological system identified by this report.

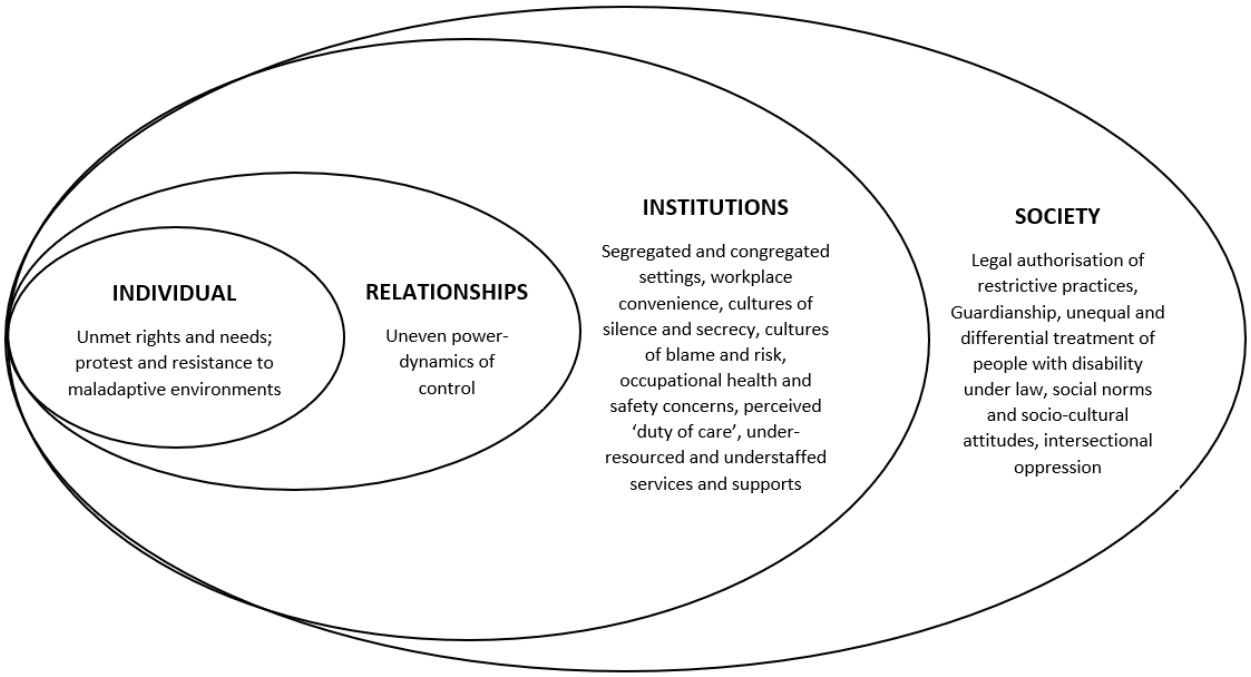


Figure 1: The ecological system of restrictive practices as identified by people with disability

As the figure above illustrates, in the context of restrictive practices, our report found the ecological system of violence, coercion and control to include the following interconnected elements driving and enabling use of restrictive practices:

1. **'Individual' Considerations: Assumptions about 'behaviours of concern'.** Restrictive practices are often presented as a necessary response to an individual person with disability's perceived 'behaviours of concern'. The report shows that interactions commonly classified as 'behaviours of concern' are better understood as both 'adaptive behaviours to maladaptive environments',[1] and as communications of distress, protest and resistance in a historical context of vulnerability and dependency where others (i.e., service providers, teachers) are empowered to interpret the behaviours of people with disability as 'dangerous, frightening, distressing or annoying'.[2]
2. **'Relationship' Considerations: Uneven Power-dynamics of control.** Interacting with and extending from assumptions about 'behaviours of control' are the enveloping relationships between people with disability and those who are tasked with supporting them in a range of contexts and settings. The report shows how the use of restrictive practices breaks down relationships of trust between people with disability and those who are tasked with supporting them, as well as further entrenching already unequal power relationships.
3. **'Institutional' Considerations: Segregation, workplace concerns, and under-resourced sectors.** Relationships between people with disability and those tasked with supporting them take shape in institutional and organisational contexts. The research literature is

unequivocal: people with disability are subject to the greatest use of restrictive practices in segregated and congregated contexts where people with disability are clustered together. Research suggests people with disability's lack of choice and autonomy within segregated and congregated settings is a distinguishing factor that contributes to the increased use of restrictive practices in these particular settings. Research also suggests that both within and beyond segregated and congregated settings, there are five core workplace concerns that appear to work both separately and together to drive use of restrictive practices:

a. Experience levels of staff. Research suggests that staff who have worked in their role for a long period of time are more likely to use restrictive practices against people with disability than staff who are less experienced in the role. Studies suggest that more experienced staff are often resistant to change, even after receiving contemporary training. This resistance to change can occur because staff express a preference to do things in the same way that they always have; staff hold beliefs that the old way of doing things is the best; and/or because of four other complex, workplace dynamics outlined separately below.

b. Institutional cultures of blame and risk management. One of the workplace dynamics that appears to inform and shape staff views about restrictive practices is an institutional culture of blame and risk management. Studies suggest a blaming culture within institutions and organisations can increase staff preoccupation with risk. This focus on risk can then contribute to persistent stigmatising beliefs about people with disability as inherently risky and/or dangerous. In many organisational settings, this persistent stigmatising belief typically centres around perceived 'behaviours of concern'.

c. Occupational health and safety concerns of staff. Australian research has identified a growing number of organisations which justify increased use of restrictive practices by reference to occupational health and safety concerns of staff. These concerns both emerge from, and play out within, a context where there are uneven power dynamics between those who 'work' and those who 'reside' in these formally administered settings. These uneven power dynamics set the scene for the occupational health and safety concerns of staff to be prioritised over the rights of people with disability in these settings.

d. Staff perceptions about their 'duty of care' obligations. A duty of care is a legal obligation to avoid doing things that could foreseeably cause harm to another person. Research suggests staff may work with vague or incorrect proximations of duty of care obligations. Restrictive practices may therefore be used as a mechanism by staff to avoid perceived situations of harm where staff believe they could be held legally liable if they do not take action.

e. Under-resourced services and supports for people with disability. Research suggests there is an association between the resourcing of the workplace, staff perceptions of safety, and staff attitudes towards and use of restrictive practices for the purposes of maintaining a 'safe' environment. In practice this can mean that some staff may use restrictive practices as one of the primary tools via which they can negotiate the broader structural and economic issue associated with an under-resourced and understaffed disability sector.

Notably, restrictive practices are also often shrouded by institutional cultures of silence. These cultures see the actions of staff that occur in the workplace – including decisions to use restrictive practices as a matter of convenience or control – not being discussed with the person with disability nor anyone else external to the organisation.

4. **'Societal' Considerations: Enveloping social norms and enabling laws.** Ableist views towards people with disability position people with disability as lesser than and naturally unequal to people without disability. These views legitimate beliefs that people with disability can and should be subject to violent and coercive forms of intervention that would not be tolerated in relation to people without disability. Research suggests ableist views can often be disguised in the service and support sector as benevolence; as a 'commitment to care', or well-intended 'protection' for people with disability. For some people with disability, use of restrictive practices is further shaped and rationalised by other forms of prejudice and discrimination, including racism and sexism.

   Currently, there are few, if any, consequences for staff who use restrictive practices against people with disability. This is because, currently, restrictive practices are permitted and regulated via law and policy. This permission sustains institutional cultures of silence, and further enforces the unequal power relationships between people with disability and service providers. Ultimately, law enables use of restrictive practices by not holding those who use them to account, and by denying redress to those who are subjected to them.

Finding Four: Positive behaviour support has a mixed and inconclusive evidence-base

Several current national frameworks or principles for reducing and/or eliminating restrictive practices emphasise investment in positive behaviour support (PBS). The report provides a review of scholarly national and international literature on PBS. This review produced five core findings:

1. **An evidence-base with distinct limitations.** Many studies of the effectiveness of PBS are based on very small sample sizes. Moreover, much of the PBS evidence-base raises questions about the strength, accuracy and integrity of the findings. These limitations have led some researchers to classify this evidence-base as 'emerging' and not established.

2. **A focus on staff training.** The evidence-base for PBS is characterised by a focus on staff training. This focus appears to be underpinned by an assumption that there is a connection between staff training and positive outcomes for people with disability, in particular, improved quality of life. This assumed connection is both infrequently studied, and on the rare occasion it has been studied, does not prove true.

3. **A focus on the quality of plans, which prove to be poor quality.** There appears to be a belief that better staff training and knowledge of PBS will lead to better behaviour support plans being developed for people with disability. These better plans are then assumed, again, to lead to positive outcomes for people with disability. Studies of behaviour support plan quality typically find behaviour support plans to be of 'poor' or 'remarkably low' quality.

4. **Mixed and inconclusive results about the overall effectiveness of PBS.** There are mixed or inconclusive findings about the overall effectiveness of PBS. Some studies note positive outcomes. Some studies find positive effects in relation to some elements, but not others. Other studies draw inconclusive findings or findings of no effect.

5. **The relationship between the environment and the person.** In studies that provided details about the nature of the 'intervention' that took place to produce a positive outcome, what appears to have changed is the quality of the environment and service being provided to the person with disability. Positive outcomes appear to occur for people with disability when: (a) staff are nonconfrontational and consistent in their communication with the person with disability; (b) staff do not impinge on the autonomy of the person with disability; (c) people with disability are enabled to participate in meaningful activities of their choosing; and (d) the wishes of the person with disability are listened to and acted upon. Such findings are consistent with the understanding that perceived 'behaviours of concern' are distress, protest and resistance made in a context of maladaptive 'environments of concern'. These findings also raise important questions about the standards and quality of contemporary disability services and supports.

Case examples of evaluated approaches to reducing restrictive practices

Three key international approaches to reducing restrictive practices have been studied, and have had some success in reducing restrictive practices. These three examples have been adopted by several countries over the years, including, in two of the cases, Australia. The examples are:

1. **The 'No Force First Project': England.** The No Force First project works from the proposition that effective recovery for people receiving services requires enabling people's 'choice, self-determination, and personhood.'[3] Within this context, any form of force or coercion is understood to ultimately undermine the person's recovery. Studies of the No Force First approach have shown reductions in seclusion and physical and chemical restraint in both general mental health wards, mental health crisis services, and forensic mental health wards. The No Force First approach has also been used in the context of forensic learning disability wards with some success. However, an evaluation found that there was a significantly higher prevalence of physical restraint and harm in forensic learning disability wards as compared to forensic mental health wards, with this difference remaining post-introduction of the No Force First approach.[4]

2. **Six Core Strategies to Reduce Seclusion and Restraint Use: USA.** The Six Core Strategies propose a trauma-informed approach to services. The strategies can be summarised as: (1) leadership towards organisational change; (2) use of data to inform practice; (3) workforce development; (4) use of seclusion and restraint prevention tools; (5) consumer roles in inpatient settings; and (6) debriefing techniques. Studies of the Six Core Strategies approach have shown reductions in restraint and seclusion in

specialised mental health organisation, general mental health wards, and adolescent psychiatric hospitals. Recently, the Six Core Strategies was adapted as part of the 2019 Australian College of Mental Health Nurses, *Safe in Care*, *Safe at Work Toolkit* for use in Australian mental health contexts. The *Toolkit* has not been formally evaluated at this time.

3. **The 'Safewards' Model: England.** Safewards is a clinical model for the management of conflict in mental health settings. The Model was originally developed as a tool to create a safer environment for both staff and patients. While the Safewards Model includes consideration of restrictive practices use, the model has a broader focus on understanding conflict, its causes, and staff responses to it. The Safewards Model has shown some positive effects in the context of general mental health settings. Evaluations of the model in other settings have provided mixed results. The Safewards Model has been implemented in a range of different jurisdictions around the world, including in the Australian states of Queensland, New South Wales and Victoria. Evaluations of the Model in these Australian jurisdictions provides mixed results.

Recommendations

The report demonstrates how restrictive practices occur within, and are driven by, an extending and encompassing ecological systemic system of violence, coercion and control. To eliminate restrictive practices, it is recommended that governments of Australia work through this ecological system in reverse order. By addressing elements present in the outer circles of the ecological system first, elements identified in the inner circles may become easier to address, or may no longer be apparent. The report proposes an eight-point action plan for eliminating restrictive practices. The box below outlines the plan, distinguishing between the 'society', 'institutional', 'relationships', and 'individual' elements of the ecological system of violence coercion and control.

Eight-point action plan to eliminate restrictive practices

SOCIETY

1. **Prohibit Restrictive Practices**

End legal authorisation for use of restrictive practices

2. **Change Attitudes and Norms**

Support awareness raising to address discriminatory attitudes and norms

3. **Acknowledge and Address Historical Injustice**

Publicly acknowledge past wrongs, support truth telling

INSTITUTIONS

4. **Deinstitutionalise and Desegregate**

Deinstitutionalise and desegregate environments

RELATIONSHIPS

5. **Recognise the Autonomy and Leadership of People with Disability**

Support exercise of legal capacity

6. **Utilise Trauma Informed Support Approaches**

Reform service systems to recognise and respond to people with disability using trauma informed approaches

INDIVIDUAL

7. **Adequately Resource Independent Living and Inclusion**

Fully resource and realise Article 19 CRPD rights to independent living and inclusion

8. **Provide Redress for Victim-Survivors**

Seek to rectify injustice through law reform and a national redress scheme

Recommendation 1: Prohibit restrictive practices.

It is recommended governments in Australia impose an immediate legal prohibition of use of restrictive practices on a discriminatory basis against people with disability. This recommendation is consistent with obligations under international law, the rights and dignity of people with disability, and established violence prevention principles that have been operationalised in relation to other marginalised populations.

Recommendation 2: Change social attitudes and norms related to people with disability.

It is recommended governments in Australia invest in strategies to change the socio-cultural attitudes and norms driving restrictive practices. The Convention on the Rights of Persons with Disabilities (CRPD) places clear obligations under Article 5, 12 and 13 to prohibit discrimination and ensure equality before the law and equal access to justice. The CRPD further stresses that people with disability are owed equal rights to protection from violence, as articulated by Articles 14-17. Steps taken to change socio-cultural attitudes and norms are consistent with 'awareness raising' obligations described by Article 8 CRPD, which extend to activities by States and society to 'combat stereotypes, prejudices and harmful practices relating to persons with disabilities.'

Recommendation 3: Acknowledge and address historical and ongoing injustice associated with use of restrictive practices.

Elimination of restrictive practices will require commitment to a process which acknowledges that society and law have perpetrated a historical and ongoing injustice against people with disability. It is recommended governments in Australia invest in structural responses of truth and repair in relation to those who have experienced restrictive practices. These structural responses must engage professions (e.g., medical, health, education, social work and law), services and the broader public in learning about the harms and injustices of restrictive practices, and in reckoning with, and being accountable for, meaningful change.

Recommendation 4: Deinstitutionalise and Desegregate.

It is recommended that governments in Australia commit to *full* deinstitutionalisation and desegregation of the living environments of people with disability. Research indicates that to facilitate full deinstitutionalisation of people with disability, there must be a commitment to deinstitutionalisation, a change in attitudes towards people with disability, community development that enables full inclusion and participation of people with disability, as well as a rights-based and transformative policy shift towards housing.

It is further recommended that governments address segregation of environments beyond housing that people with disability also find themselves within. This means ending segregation in systems that currently only apply to people with disability such as 'special' or segregated schools, Australian Disability Enterprises (ADEs), group homes, day centres, and mental health facilities. Ending segregation of people with disability would align with violence prevention and safety enhancement approaches identified in the Royal Commission into Institutional Responses to Child Sexual Abuse.

Recommendation 5: Recognise the autonomy of people with disability.

It is recommended that governments in Australia respect and protect the autonomy of people with disability to make decisions about what happens to their bodies and lives. This recommendation for autonomy is consistent with obligations outlined in the CRPD, particularly Article 12 on equality before the law, and Article 19 on independent living and community inclusion, as well as Article 21 on freedom of expression and opinion, Article 29 on participation in political and public life, and general principles in Article 3. Enhancing the autonomy of people with disability in relation to First Nations people with disability needs to be understood in the broader context of Indigenous and First Nations self-determination and nation-building.

Recommendation 6: Utilise trauma-informed support approaches.

Restrictive practices are traumatic. It is recommended that governments in Australia facilitate trauma-informed approaches to service-delivery, particularly within the human services sector. This recommendation is consistent with the obligations outlined in Article 16 of the CRPD.

Recommendation 7: Adequately resource independent living and full inclusion

The report recommends adequate resourcing for realising people with disability's rights to independent living and full inclusion, as well as economic, social and cultural rights. Article 19 CRPD provides a clear vision for enabling independent living and community inclusion for people with disability. This Article interconnects with economic, social and cultural rights, including rights to education, health, housing and social security. Realising these rights of people with disability will help to reduce or remove the circumstances of inequality, control, coercion, segregation, and confinement that are drivers of and form part of the ecological system of restrictive practices, and enhance their overall status in society.

Recommendation 8: Provide redress for victim-survivors.

The elimination of restrictive practices requires commitment to a process which acknowledges that society and law have perpetrated a historical injustice against people with disability. This extends to providing forms of just rectification, including redress for victim-survivors. It is recommended governments of Australia invest in redress options for victim-survivors of restrictive practices.

There are two different approaches to supporting access to redress – first, through the criminal and civil justice systems, and second through a proposed national redress scheme. For people with disability, a redress scheme can potentially be more accessible, affordable and efficient than court litigation. A redress scheme is also capable of making redress available to a larger group of individuals (including those who have experienced lawful restrictive practices or historical restrictive practices), and is not dependent on the present-day existence and/or wealth of the perpetrators. From a human rights perspective, a redress scheme is particularly significant because it can redress all human rights violations irrespective of whether they were unlawful under domestic law. A redress scheme should operate alongside court remedies, and access to one should not prevent access to the other. Attention must also be paid to improving access to justice in the criminal and civil justice systems for victim-survivors of restrictive practices.

Introduction

Restrictive practices have been identified as a key area of inquiry for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (the Disability Royal Commission).[5] This report provides guidance to the Disability Royal Commission in relation to the Commission's objective to reduce and eliminate restrictive practices. In this introductory chapter we provide the definition for restrictive practices upon which this report is based, detail the research questions, method and scope of the research project that underpins the findings of the report, and outline the chapter structure of the report.

1.1 Restrictive practices as violence against people with disability

There is potential for a lack of clarity about what constitutes a 'restrictive practice.' One issue is that the term has emerged within a particular policy and legislative context as applied specifically to people with disability and distinct to broader legal and social definitions of violence. This context is potentially a problem where understandings of what constitutes 'violence' against people with disability differs from how violence is understood in the broader community. Indeed, as this report will discuss, this context is one of the areas of human rights concern which relates to use of restrictive practices. This section aims to outline a definition of restrictive practices that will be consistently applied through this report.

The Disability Royal Commission understands that the term 'restrictive practice' is commonly used in Australia 'to refer to any action, approach or intervention that has the effect of limiting the rights or freedom of movement of a person'.[6] This definition closely aligns with the broad definition of restrictive practices utilised by the National Disability Insurance Scheme: 'restrictive practice means any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability.'[7]

The Disability Royal Commission and National Disability Insurance Scheme definitions are useful because they are broad and might include a range of practices shaping the lives of many people with disability. It is possible, however, to refine these definitions, provide more specificity as to the way in which these practices are targeted and authorised, and to centre the human rights and lived experiences of people with disability. Below we set out some of the human rights and legal dynamics that provide the basis for the refined definition of restrictive practices upon which this report will be based.

Restrictive practices are a key area of concern for people with disability. As Chapter 2 of this report will detail, restrictive practices represent a significant site of violence and coercion for people with disability. Further, and importantly, restrictive practices are at odds fundamentally with the human rights of people with disability. In the 2020 *Restrictive Practices Issues Paper*, the Disability Royal Commission recognised that restrictive practices may conflict with many of the rights of people with disability.[8] As Chapter 1 of this report will detail, restrictive practices run counter to several human rights treaties, including the Convention on the Rights of Persons

with Disabilities (CRPD), the International Covenant on Civil and Political Rights, the Convention on the Rights of the Child, and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

The conflict between use of restrictive practices and the rights of people with disability in Australia is significant. The conflict has been subject to international scrutiny. The former United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E Méndez, has called for all countries to introduce:

> an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities … in all places of deprivation of liberty, including in psychiatric and social care institutions.[9]

We note that there is an absolute non-derogable prohibition on torture and cruel, inhuman or degrading treatment or punishment under international law.

The findings of the Special Rapporteur resonate with the UN Committee on Rights of Persons with Disabilities which oversees compliance with CPRD. The UN Committee has called specifically on Australia to develop:

> a nationally consistent legislative and administrative framework for the protection of all persons with disabilities, including children, from the use of psychotropic medications, physical restraints and seclusion under the guise of "behaviour modification" and the elimination of restrictive practices, including corporal punishment, in all settings, including the home.[10]

This recommendation by the UN Committee on Rights of Persons with Disabilities aligns directly with the recommendation made by Disabled People's Organisations in Australia.[11] The recommendation is thus representative of the views and goals of people with disability themselves.

Despite the strong condemnation of use of restrictive practices by Disabled People's Organisations and the international human rights community, there has not been significant progress in Australia towards prohibition and elimination of these practices. Instead, some forms of restrictive practices are authorised and regulated. Under the *National Disability Insurance Scheme* (*Restrictive Practices and Behaviour Support*) *Rules 2018*, the following forms of restrictive practices are listed as subject to regulation:

- *Seclusion*: 'the sole confinement of a person with disability in a room or a physical space at any hour of the day or night where voluntary exit is prevented, or not facilitated, or it is implied that voluntary exit is not permitted.'[12]

- *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.'[13]
- *Mechanical restraint*: 'which is 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.'[14]
- *Physical restraint*: 'which is 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.'[15]
- *Environmental restraint*: 'which restrict a person's free access to all parts of their environment, including items or activities.'[16]

As Chapters 4 and 5 of this report will make clear, there are at least two serious issues associated with Australian governments' choosing to regulate specific forms of restrictive practices. First, when specific forms of restrictive practices are subject to regulation while o thers are not, this differentiation can obscure the full range of harms people with disability experience through restrictive practices. As indicated above, restrictive practices 'refer to any action, approach or intervention that has the effect of limiting the rights or freedom of movement of a person'.[17] This includes those practices which are currently regulated – i.e., seclusion, chemical restraint, mechanical restraint, physical restraint, and environmental restraint – but it also includes all other interventions in the lives or bodies of people with disability that limit the rights or freedom of movement of a person, including guardianship, forced sterilisation, financial management, involuntary mental health treatment, and interventions said to be undertaken for behavioural or medical treatment reasons. While these other interventions meet the definition of 'restrictive practice', they are subject to inconsistent degrees and forms of regulation pursuant to other law and policy frameworks. Second, as the Senate Community Affairs References Committee found in their inquiry into violence, abuse and neglect against people with disability in institutional and residential settings, choosing to regulate some restrictive practices instead of prohibiting all restrictive practices means that people with disability in Australia are being lawfully subject to harms that would be considered crimes if they were committed against people without disability.[18]

Given the serious issues associated with use of restrictive practices in Australia, and based on the forthcoming findings presented in the chapters of the report, the authors of this report have devised the following definition of restrictive practices for use in this report and elsewhere:

Restrictive practices are legally authorised and/or socially and professionally sanctioned violence that targets people with disability on a discriminatory basis and are at odds with the human rights of people with disability. Restrictive practices include, but are not limited

to, chemical, mechanical, physical and environmental restraint and seclusion, guardianship, forced sterilisation, menstrual suppression and anti-libidinal medication, financial management, involuntary mental health treatment, and other non-consensual or coercive interventions said to be undertaken for protective, behavioural or medical reasons.

The above definition of restrictive practices offers a greater degree of precision in highlighting the specific nature and problem of restrictive practices as they are applied against people with disability. First, restrictive practices represent a form of violence people with disability experience that is legally and/or socially and professionally sanctioned. This means that this violence not only has formal authorisation by law and policy, but it is also embedded as a practice in formal and informal settings with a significant degree of social and professional endorsement. In Chapters 3, 4 and 5 we consider the social and professional endorsement of restrictive practices in detail.

Second, we note that our understanding of 'violence' extends to 'coercive and non-consensual' interventions, as described above by the United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Whether use of restrictive practices can be legitimated if its recipient has previously consented – but does not consent at the time of application – is contentious, and will be discussed further in Chapter 1. However, the above definition assumes that a restrictive practice is by definition a 'coercive and non-consensual' measure; that is, a form of violence.

Third, the definition we provide emphasises that the term 'restrictive practices' refers to a range of practices used against people with disability on a discriminatory basis. It is worthwhile clarifying in this context what is meant in this report by 'the use of restrictive practices on a discriminatory basis against people with disability'. This is discussed in the box below.

Restrictive Practices and Discrimination

Use of restraint and seclusion can be legally authorised in a range of contexts. For example, use of restraint and containment is a central element of the 'reasonable force' powers of the police that apply to members of the general population who come into contact with police.[19] In disability specific contexts, uses of restraint and seclusion are generally authorised by discrete policy and legislation, and are intended for use only against people with disability.[20]

In this case, many people with disability are subject to differential treatment under the law with respect to the authorisation of restraint and seclusion.

On the face of it, the differential treatment of people with disability with respect to the authorisation of restraint and seclusion is potentially at odds with Article 5.1 CRPD which prohibits 'all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.' However, it is important to note that under international human rights law 'not every differentiation of treatment will constitute discrimination, if the criteria for such differentiation are reasonable and objective.'[21] On this basis, some might argue that the differential treatment of people with disability in relation to restrictive practices is 'reasonable and objective.' However, Chapters 3,4 and 5 of this report highlight that use of restrictive practices is driven by institutional and segregated environments and lacks a strong evidence base to support their efficacy. It might alternatively be argued by some that restrictive practices are protective and advance the rights of people with disability. Article 5.4 CRPD states that 'specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention.' However, it is not clear that a strong case can be put forward that the differential provisions relating to use of restrictive practices against people with disability 'are necessary to accelerate or achieve de facto equality of persons with disabilities'. On the contrary, as observed in Chapter 1 of this report, the differential use of restrictive practices against people with disability undermines fundamental rights and dignity, and constitutes one important way in which the social status of people with disability is injured in our society. Chapter 2 of this report, in describing the experiences of people with disability themselves, highlights the way in which the use of restrictive practices undermines the dignity of people with disability. Thus, in this report, it has been assumed that use of restrictive practices against people with disability, authorised on a differential basis, are formally, and in effect, discriminatory.

Given the above concerns with the differential treatment of people with disability under the law with respect to the authorisation of restraint and seclusion, this report suggests that human rights law demands a legal prohibition of the use of restrictive practices on a discriminatory basis against people with disability. However, it is beyond the scope of

this report to argue that all restraint and seclusion should be generally prohibited under law. Firstly, as stated above, restraint and seclusion are used in a range of policing and custodial contexts. While this report stresses that human rights obligations and rules, such as expressed in the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), provide guidance on the use of restraint in a range of contexts, including against people with disability, it is out of scope for this report to review the use of restraint and seclusion by police or correctional officers against the wider population.

Secondly, it is important to note that existing non-disability-specific provisions under law may conceivably allow for the non-discriminatory application of restraint and seclusion, including against people with disability, when these practices are used in 'instances of last resort … where there is a serious and urgent risk to the individual's health or life, or a risk to the safety of others.'[22] There already exist provisions under the law for the use of reasonable force in situations that might extend to a 'last resort' circumstance that apply to the general population. Such provisions highlight that it may be unnecessary to require differential legislative treatment targeting people with disability in order to respond to 'last resort' situations. As described above, police have powers to use reasonable force which are general, rather than specific to people with disability or any other group. Further, police are not the only individuals granted the capacity to use reasonable force. For example, many Australian states and territories also maintain so called 'good Samaritan' provisions which provide civil immunity for actions taken by individuals 'in an emergency when assisting a person who is apparently injured or at risk of being injured.' [23]

In theory these examples of general authorisation, or civil immunity, for the use of force in an instance of last resort are not formally discriminatory against people with disability, since they do not rely on differential legislation that targets people with disability as the subjects of this application of force. However, it should be noted that non differential treatment, while formally non-discriminatory, may nevertheless be discriminatory in effect; for example, if a population group is singled out by the police or others for use of force in a way that is not reasonable and objective. While this issue is beyond the scope of this report, we note that Article 5 CRPD provides guidance that 'all discrimination' is prohibited; this extends beyond formal forms of discrimination to take into account the demand for substantive equality, addressing 'structural and indirect discrimination.' [24]

Lastly, these practices are at issue because they are at odds with, and significantly violate the human rights of people with disability because of the nature of the practices (that is, potentially as torture and ill-treatment), their discriminatory application, and the legal and other barriers which prevent equal access to justice and remedy for violence, torture and ill-treatment. We engage further with the human rights of people with disability in the next Chapter, Chapter 1.

1.2 Research project background and scope

This report is based on a nine-month research project. The objectives and research questions of that project were set by the Disability Royal Commission. The objectives for the project were:

1. To identify and analyse systemic drivers of the use of restrictive practices across settings across Australia.
2. To identify and analyse strategies to reduce and/or eliminate the use of restrictive practices and exclusion.
3. To examine whether the existing findings of the Royal Commission in relation to positive behaviour support generalise in relation to other types of restrictive practices and disabilities. Here we note that Public Hearing 6 did not provide sufficient evidence to determine why positive behaviour support may be viewed by some as a best practice response to perceived 'behaviours of concern', nor if positive behaviour support is effective in reducing the full range of restrictive practices used against all people with disability.
4. To undertake this research in alignment with the Terms of Reference of the Royal Commission.
5. To inform the Royal Commission's policy development, identification of possible solutions, and recommendations for its final report.

The research questions set by the Disability Royal Commission for the research project were:

RQ1: What are the systemic drivers of the use of restrictive practices against people with disability? How do these differ across settings across Australia?

RQ2: What measures and strategies are most effective in addressing these drivers and reducing or eliminating the use of restrictive practices against people with disability? Does this differ by setting, or by the type of restrictive practice? What measures have been proven ineffective in addressing restrictive practices?

RQ3: Is positive behaviour support effective in reducing and eliminating the use of restrictive practices? Is it more effective in relation to certain types of disabilities, certain restrictive practices, or certain settings?

RQ4: Are there local and international models of policies and practices that have resulted in effective reduction in the use of restrictive practices?

Below at Table 1, we provide an outline of the relevant sections of the report which respond to the research questions set by the Disability Royal Commission. Note we take account of each sub question. The 'notes' column lists relevant observations on interpretation, data availability and the ability to draw conclusive and generalisable findings in relation to the research questions.

Table 1: Sections of report where research questions addressed

Research Question	Chapter, Section	Notes
RQ1 What are the systemic drivers of the use of restrictive practices against people with disability?	Chapters 3 and 4	Chapter 3 uses lived experiences of people with disability to highlight the ecological features surrounding use of restrictive practices. Chapter 4 explores systemic drivers and enablers of restrictive practices based on a survey of research literature.
RQ1 How do these differ across settings across Australia?	Chapters 3 and 4	While the report notes specific settings, it is difficult to determine from the research available precisely how systemic drivers of the use of restrictive practices against people with disability differ across settings across Australia.
RQ2 What measures and strategies are most effective in addressing these drivers and reducing or eliminating the use of restrictive practices against people with disability?	Chapter 5	While we explore a range of strategies, it is unclear from current policy and research literature to what extent these measures and strategies have been developed with consideration of the drivers and enabler of restrictive practices established in Chapter 4. As such, the ability to assess the effectives of current strategies in addressing drivers is limited. Further research is required to address these areas of interest for the Disability Royal Commission.
RQ2 Does this differ by setting, or by the type of restrictive practice?	Chapter 5	Where possible, attention is drawn to the settings where measures and strategies are used. However, there has been little to no research conducted to date on the effectiveness of these measures and strategies in specific settings, including if certain measures have proven ineffective in addressing restrictive practices. We were also unable to identify any research that considers if there are differences in effectiveness between settings. It is not possible from the limited material available for this project to draw such generalisations. Further research is required to address these areas of interest for the Disability Royal Commission.

Research Question	Chapter, Section	Notes
RQ2 What measures have been proven ineffective in addressing restrictive practices?	Chapter 5	As above, existing research is limited thus making it difficult to draw generalisable conclusions. However, where possible, the report points to areas where there is evidence of limited effectiveness, such as staff training.
RQ3 Is positive behaviour support (PBS) effective in reducing and eliminating the use of restrictive practices?	Chapter 5, Section 5.2.3	As noted in 5.2.3.1, there are limits on the quality of the research available, either because of small sample sizes, or because of strength, accuracy and integrity.
RQ3 Is it more effective in relation to certain types of disabilities, certain restrictive practices, or certain settings?	Chapter 5, Section 5.2.3	Our review of PBS research considers use of PBS in a range of settings – specifying those settings as they relate to the research findings. It is not possible from the research literature currently available to generalise if PBS is more or less effective in certain settings. Nor is it possible to determine if there are differences in effect when PBS is used in relation to certain types of disabilities, or certain restrictive practices. Further research is required.
RQ4 Are there local and international models of policies and practices that have resulted in effective reduction in the use of restrictive practices?	Chapter 5, Section 5.1	We were unable to identify any national or international examples of approaches to reduction and/or elimination that were developed for disability service settings and have been evaluated for effectiveness.

1.3 Methodology

The research project adopted a disability human rights methodology. This methodology aligns with the centrality of human rights to the Disability Royal Commission's work.[25] In practice this means the research project included elements that were both participatory (see 1.3.2 below), as well as emancipatory – that is, seeking explicitly to arrive at conclusions that realise the rights of people with disability.[26] To do this participatory and emancipatory work, data collection and analysis was undertaken in three, connected parts, as outlined in sections 1.3.1-1.3.3 below, and as illustrated through Figure 2 below.

Figure 2: Methodological Approach to centring the experiences and rights of people with disability.

1.3.1 Centring the experiences and rights of people with disability

The project sought to centre the experiences and rights of people with disability when identifying and analysing both the drivers for restrictive practices, and the pathway toward their elimination. This approach conforms with the importance placed by the Disability Royal Commission on ensuring that:

> people with disability are central to processes that inform best practice decision-making on what all Australian Governments and others can do to prevent and respond to violence against, and abuse, neglect and exploitation of, people with disability.[27]

While the experiences of legal, medical and health professionals as well as service staff are also explored in this report (particularly in Chapters 4 and 5), the human rights approach taken necessitates that highest priority is given to people with disability, and particularly, to listen to and learn from individuals with disability who have experience of restrictive practices. Our approach of centring the voices of people with disability also aligns with the approach in other Royal Commissions into institutional harm, where the voices, experiences and feelings of victim-survivors and their communities have been centred and prioritised over the perceptions and experiences of members of the professional and staff groups responsible for perpetrating harms (e.g., Royal Commission into the Protection and Detention of Children in the Northern Territory, Royal Commission into Institutional Responses to Child Sexual Abuse, Royal Commission into Aboriginal Deaths in Custody).

As described below at 1.4, it was not possible in the timeframe provided for this research project to include an empirical component – that is, to directly interview or survey people with disability subject to restrictive practices as part of the project. While further research of this kind is needed, such studies require substantial time and planning, particularly to ensure ethical considerations are adequately addressed. The time frame for the Disability Royal Commission would not allow for such a careful empirical study to occur in preparation of this report.

However, given the longstanding concerns raised by people with disability on use of restrictive practices, it was possible to capture experiences of people with disability from previous studies and inquiries. To this end, the research team searched scholarly literature, reports, government inquiries, and submissions made to those inquiries to collect and analyse the accounts of people with disability who have been subject to restrictive practices. The research team also collected from this material some accounts of parents of children and young people with disability who describe a person with disability's experience of restrictive practices, as well as some accounts of the partners and children of older people with disability in aged care. We refer to the full collection of material as the 'experiential data'.

Collecting the 'experiential data' means the analysis presented in this report was built on foundational understandings of restrictive practices provided in research conducted with and/or by people with disability, as well as submissions to public inquiries made by people with disability, or by their representative organisations. As indicated below at 1.3.2, this research was further supported by an Expert Reference Group that included a majority of representatives from Disabled People's Organisations. As such, we believe that the approach of this report thoroughly aligns with Article 33.3 of the CRPD, which stresses the involvement of people with disability and their representative organisations in policy development,[28] and conforms with principles laid out in the Letters Patent that established the Disability Royal Commission.

Chapters 2 and 3 of this report provide dedicated analyses of the experiential data collected. These two substantial chapters amplify the voices of people with disability and those closest to them to articulate both the experience of restrictive practices, and the ecological system within which these practices take shape.

1.3.2 Expert reference group

As indicated above, a second way the research project sought to centre the experiences and rights of people with disability was through the inclusion of an Expert Reference Group comprising representatives from Disabled Peoples Organisations in Australia. The Expert Reference Group served a function in our disability human rights methodology of ensuring that the disability community 'have ownership and guidance of research in all phases of the research process'.[29]

The reference group met six times over the life of the project. The functions of the group were to:

1. Provide initial feedback and guidance on research project design and assist with refinement.
2. Verify and refine the guiding principles of the project in line with relevant human rights obligations and the lived experiences of their organisations' members with disability.
3. Provide leads and direction for literature review and case examples, including by reference to their advocacy experiences and international networks.
4. Provide relevant systemic advice on disability policy and law landscape, including by reference to their advocacy experiences and international networks.
5. Provide ongoing monitoring on project outcomes.
6. Provide feedback on draft report prior to finalisation.

1.3.3 Review of academic and grey literature

After centring the experiences and rights of people with disability to identify both the ecological system and drivers for restrictive practices, as well as the pathway toward elimination, the project used academic and grey literature to analyse these drivers and pathways in further detail.

In relation to the systemic drivers of the use of restrictive practices across settings in Australia (RQ1), our analysis of the literature included consideration of residential settings, including group homes, other supported accommodation settings, and in the private home (e.g., under a guardianship order); mental health settings; aged care settings; educational settings; out-of-home-care settings; employment settings (e.g., Australian Disability Enterprises); justice settings, among others.

In relation to the pathway to elimination (RQ2), our analysis included consideration of current strategies for reducing and eliminating restrictive practices, including a detailed consideration of positive behaviour support (RQ3). Noting the Disability Royal Commission's focus on responding to and preventing violence in a human rights framework, and the limitations of current strategies in addressing the ecological system and drivers for use of restrictive practices, we also considered rights-based approaches, including legal prohibition, deinstitutionalisation and desegregation approaches, supported decision-making, and redress, among others.

As part of this process, we identified and included examples of local or international policies and practices that have had some success in reducing use of restrictive practices (RQ4).

To ensure the inclusion of both multidisciplinary scholarship, as well as scholarship that incorporates diverse research designs – including qualitative, quantitative, and mixed-method approaches – the research team sourced the academic and grey literature from:

1. The leading generalist research databases, including EBSCO, Scopus, and ProQuest.
2. Specialist research databases, such as ERIC (educational settings research), HeinOnline (legal research), and PsycINFO (behavioural and social science research).

Following our guiding principles of centring the lived experience and rights of people with disability in our research, this report prioritises academic literature produced by or in consultation with people with disability and/or representative organisations.

1.4 Limitations

As noted above, the research team were provided with nine-months to complete the research project. Within this timeframe, it was not possible to conduct a new empirical study of the experiences of people with disability who have been subject to restrictive practices. The report instead drew on secondary empirical data about people with disability's experiences of restrictive practices collected from scholarly literature, reports and government inquiries.

Contemporary research into use of restrictive practices is marked by several limitations. These limitations in turn shape the scope and limits of this report. There has been little scholarly research into the experiences of people with disability subject to restrictive practices in Australia. For this reason, the report includes experiences of people with disability who live in other, comparable countries. There has also been little to no research into the specific experiences of restrictive practices for LGBTQIA+ people with disability, or culturally and linguistically diverse people with disability. Only a few studies consider the experiences of First Nations peoples with disability.

Additionally, while people with disability's experiences of some forms of restrictive practices are well explored – such as experiences of seclusion or involuntary mental health treatment – experiences of other forms of restrictive practice such as guardianship or financial management are rarely considered. This disparity in accounts is at least in part reflective of the opportunities that have and have not been provided to people with different types of disability to articulate experiences of restrictive practices over the years. Very few researchers venture into group homes to speak with people with disability, and, to the best of our knowledge, few, if any, attempts have been made to capture the accounts of people with disability subject to restrictive practices in the context of Australian Disability Enterprises, day programs, out-of-home care, immigration detention, and in the family home. Each of these limitations within contemporary

scholarship impact the ability of this report to respond with strong specificity in relation to relevant research questions set by the Disability Royal Commission about observed differences between types of disability, types of restrictive practice and/or types of setting. Further research will be required to address these areas of interest for the Disability Royal Commission.

In addition to the above limitations within contemporary scholarship, we note that judicial and tribunal decisions related to authorisation of restrictive practices are not routinely published. There is also limited publicly available information on which to base exploration of the justice system's role in enabling restrictive practices. Again, further research will be required to address these areas of interest for the Disability Royal Commission.

Finally, there are also limitations inherent to contemporary research concerning strategies and approaches to reducing or eliminating restrictive practices. While there are a range of 'high-level' frameworks and principles for reducing and/or eliminating restrictive practices outlined for implementation in Australia across a range of different settings, including mental health settings, disability services settings and educational settings, there has been little to no research conducted to date on the effectiveness of these approaches. Moreover, where the question of effect has been considered internationally, this has almost exclusively occurred in the context of mental health settings alone. Again, these limitations within contemporary scholarship on strategies for reducing and/or eliminating restrictive practices impact the ability of the report to respond with strong specificity in relation to relevant research questions set by the Disability Royal Commission about observed differences in effect between different types of approaches, types of disability, types of restrictive practice and/or types of setting. Once again, further research will also be required to address these areas of interest for the Disability Royal Commission.

1.5 Structure of report

The report is structured as follows. Chapter 1 provides foundational background material for making sense of two common, interrelated threads that run throughout this report. First, the relevant human rights obligations that relate to people with disability in relation to use of restrictive practices. Second, and related, the impact of restrictive practices on the dignity of people with disability.

Chapter 2 examines some of the core, common experiences of people with disability who have been subjected to restrictive practices. The chapter draws on the experiential data collected to bear witness to the voices and experiences of people with disability who have been subject to restrictive practices. The chapter uses this experiential data to provide insight into the violence, abuse, neglect and exploitation inherent to use of all forms of restrictive practices against people with disability, and which strips people with disability of dignity.

Chapter 3 then considers the broader ecological system within which restrictive practices take shape and are perpetrated against people with disability. This chapter begins to address RQ1 set out by the Disability Royal Commission. Once again, we listen to voices and experiences of people with disability in this chapter. We draw on the experiential data collected to articulate the contours of the concentric circles of relationships, institutions and social structures that envelop and extend out from the person with disability, and which enable violence, abuse, neglect and exploitation to be perpetrated against people with disability through use of restrictive practices.

In Chapter 4 we address RQ1 from a different angle, turning to the research literature and exploring what is currently known about the systemic drivers and enablers of restrictive practices. The chapter outlines how these drivers and enablers interact and intersect with one another, and how they produce the experiences and ecological system described by people with disability in Chapters 2 and 3 of the report. The exploration of drivers and enablers includes perspectives of professionals and staff involved in use of restrictive practices, as requested by the Disability Royal Commission.

Chapter 5 provides an overview of some of the core national and international approaches that have been taken to reduce and/or eliminate restrictive practices. This overview draws on perspectives of professionals and staff involved in operation of these approaches, as requested by the Disability Royal Commission. Responding to RQ2, RQ3 and RQ4, the chapter considers both 'high-level' frameworks and principles used to guide national and international approaches to reducing and/or eliminating restrictive practices, as well as 'ground-level' practices that have been developed to operationalise these frameworks and principles, and which are used in a range of systems and service settings in Australia. Crucially, as will be discussed in detail in Chapter 5, there is limited evidence that current approaches to eliminating restrictive practices proposed and/or adopted in Australia are effective in addressing the ecological system of coercion, control and violence from within which restrictive practices are driven and enabled.

Based on the evidence presented in Chapters 1–5, in Chapter 6 we outline a pathway for eliminating restrictive practices. This pathway is based in the experiences of restrictive practices articulated by people with disability. The pathway is responsive to the drivers and enablers identified by this report and is attentive to the experiences of professionals and staff involved in use of restrictive practices. The pathways operates within a human rights framework and works to redress and repair the dignity that has been stripped from people with disability through use of these practices. Chapters 6 also contributes to addressing RQ2, RQ3 and RQ4.

Lastly the Conclusion chapter of the report draws on the findings provided across Chapters 1–6 to provide summary responses to each of the research questions set by the Disability Royal Commission in relation to restrictive practices.

Chapter 1: Restrictive practices and human rights of people with disability

The purpose of this chapter is to provide the foundational background material necessary to make sense of two common and connected themes threaded throughout this report: restrictive practices as contrary to human rights of people with disability, and restrictive practices as stripping the dignity of people with disability. To that end, in section 1.1 of this chapter, we attend to the relationship between restrictive practices and the rights of people with disability. As indicated in the Introduction Chapter of this report, restrictive practices are at odds with obligations under international law, as articulated within several core human rights treaties, including the Convention on the Rights of Persons with Disabilities (CRPD), the International Covenant on Civil and Political Rights (ICCPR), the Convention on the Rights of the Child (CRC), and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT). We engage with these human rights treaties in greater detail below.

In section 1.2 we turn to consider a related theme: the dignity of people with disability. The concept of dignity is apparent through many core human rights, and reflected in obligations to protect people with disability from torture and ill-treatment, as well as any form of discriminatory treatment. In many respects, equal treatment obligations, rights to bodily integrity and freedom from torture, ill-treatment and violence, all articulate a human right to dignity. As we shall see in Chapter 2 of this report, people with disability themselves understand their own experiences of use of restrictive practices as a process of being 'stripped of dignity'. As such, in the second section of the present chapter we explore this important concept, and discuss its implications for understanding restrictive practices and their effect.

1.1 Restrictive practices and human rights

As outlined in the Introduction Chapter, the Disability Royal Commission understands the term 'restrictive practice' is commonly used in Australia 'to refer to any action, approach or intervention that has the effect of limiting the rights or freedom of movement of a person'.[30] In this report, we have offered a refined version of this definition which foregrounds that restrictive practices are a human rights problem:

Restrictive practices are legally authorised and/or socially and professionally sanctioned violence that targets people with disability on a discriminatory basis and are at odds with the human rights of people with disability. Restrictive practices include, but are not limited to, chemical, mechanical, physical and environmental restraint and seclusion, guardianship, forced sterilisation, menstrual suppression and anti-libidinal medication, financial management, involuntary mental health treatment, and other non-consensual or coercive interventions said to be undertaken for protective, behavioural or medical reasons.

Broadly speaking, there are several human rights treaties, including ICCPR, ICESCR, CEDAW, CERD, CRC and CAT that are relevant to use of restrictive practices on people with disability. The CRPD is also a primary reference point in relation to international human rights of people with disability. This first section of the chapter outlines the rights obligations to people with and without disability, and the relevance of these obligations to the use of restrictive practices.

1.1.1 Freedom from torture and ill-treatment

There is an absolute prohibition applied against use of torture under international law. This prohibition is upheld by a range of treaties, including CAT, ICCPR (Article 7), CRC (Article 37) and CRPD (Article 15). Freedom from torture is also specifically during times of armed conflict war, under various provisions of the Geneva Conventions of 1949 (international armed conflict) and Common Article 3 of the Geneva Conventions (non-international armed conflict). This prohibition of torture, during peace time and war, is a peremptory (overriding) rule of customary international law (*jus cogens*), and may not be derogated from nor torture justified even in times of national or public emergency (ICCPR, Article 4(2); CAT, Art 2(2)).[31] In practice this means that there is a very strong obligation on prohibiting and preventing torture at all times, and without exception, such that 'no exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture'.[32] In this respect, freedom from torture is one of the most fundamental human rights obligations.

History has shown that the definition of torture is politically contentious.[33] Further, there are sometimes gaps between the public imagination of what constitutes an act of torture, and the everyday acts of violence that occur in institutional settings that 'unambiguously' represent torture and ill-treatment.[34] These factors may make it difficult to determine whether an act of violence can be considered torture within public or political discourse. However, within international law, Article 1.1 of CAT provides a clear and agreed definition:

> the term 'torture' means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

The definition above includes five elements which are relevant to consideration of restrictive practices.[35] First, torture must exceed a threshold of physical and mental pain or suffering which is 'severe'. Determining the threshold of 'severe' pain is potentially open to interpretation, however as Méndez and Nicolescu observe, the framers of the torture convention never intended the definition to only include a specific lists of acts.[36] Moreover, as Méndez and Nicolescu observe, the definition of 'severe' is contextual, and that:

> the vulnerability of the victim – including factors such as age, gender, or other status, like disability – as well as the environment and the cumulative effect of different factors, should be taken into account to determine whether a particular case amounts to torture.[37]

Second, the above definition suggests that torture must have a purpose, such as extracting a confession or punishing a person. However, the Committee against Torture has expressed the view that: (a) the list of purposes is not intended as exhaustive, and further, (b) relevant to use of restrictive practices, an act based upon 'discrimination of any kind', including 'mental or other disability, health status' is 'sufficient to fulfill the purposive element of the definition of torture.'[38] Restrictive practices, by definition, are specialised form of violence used against people with disability. As discussed below, the discriminatory use of restrictive practices against people with disability offends other rights obligations, including rights to equal protection from violence and rights to equality and non-discrimination.

Third, the definition above indicates there must be intent demonstrated. It is important to emphasise that 'intent' here is not understood as 'intent to torture' – an interpretation that was rejected during the drafting of the treaty. Instead, here the emphasise on 'intent' is meant to avoid framing unintended harm due to negligence as torture.[39] In this respect, and relevant to use of some restrictive practices, intent suggests an intentional act of violence or coercion, but does not require an explicit intent to 'torture'.

Fourth, under CAT, the definition of torture includes a requirement for State responsibility in the conduct of torture, expressed with the phrasing 'with the consent or acquiescence of a public official or other person acting in an official capacity.' This definition does not require that a formally delegated public official – such as a police officer – carry out acts for this to be understood as torture. Indeed, a feature of the widening scholarship and jurisprudence of torture under CAT and other human rights treaties, particularly as a result of feminist engagement, is an understanding that there are a range of circumstances where the State has an obligation to prevent acts of violence in non-State and private settings, carried out by 'private' individuals, which might be understood as torture.[40] This means that a policy of indifference by the State in relation to protection of individuals from torture at the hands of non-State agents is not in conformity with the Treaty. As Méndez and Nicolescu observe, this

> reasoning has been invoked directly by the Committee in its jurisprudence and concluding observations dealing with victims of gender-based violence, such as rape, domestic violence, FGM [Female Genital Mutilation], and human trafficking.[41]

Note that other core treaties, such as CRPD, ICCPR, CEDAW or CRC, do not limit their understanding of torture to acts committed by, or at the acquiescence of, public officials, and thus this adds weight to the view that direct State involvement in torture, through formally delegated public officials, is not required to demonstrate a State obligation to protect individuals from torture.[42]

Finally, the exception provided for 'pain or suffering arising only from, inherent in or incidental to lawful sanctions' is not intended to imply that domestic legal arrangements should trump international human rights norms. Indeed, the purpose of CAT is precisely to establish legal principles which guide domestic law, and not to provide expansive exceptions which undermine the principles of international law.[43] If anything, CAT provides a pathway to a wider understanding of torture and ill-treatment. This widening is to an extent implied by Article 1.2 of CAT, which opens the possibility that there may be 'wider application' of torture prevention than indicated by the definition in Article 1.1. Further, elaborations on the definition of torture, such as that provided by Article 2 of the Inter-American Convention to Prevent and Punish Torture (1985), make clear that lawful sanctions are only to be tolerated where they do not permit acts that are contrary to definition of torture established by the Article. In other words, this again emphasises that if lawful sanctions are at odds with international obligations to prevent torture and ill-treatment, then their legality under a domestic law does not provide an endorsement to continue these practices.

Relatedly, it is understood that the second sentence of Article 1.1 of CAT on 'lawful sanctions' was a product of negotiations related to the continuing use of penal sanctions such as corporal punishment by some nation states which are at odds with the principles contained in CAT.[44] However, emerging international norms see corporal punishment contrary to the obligations to prevent torture and ill-treatment, thus in a sense invalidating the intent of this section of the definition of torture.[45] Thus, in summary, although the definition provides an exception for the use of 'lawful sanctions', in contemporary practice, any form of torture that meets the definition provided in the first sentence of Article 1.1 is at odds with international law and should be prohibited.

An area of uncertainty within CAT is that no clear definition is provided within the treaty for 'cruel, inhuman and degrading treatment or punishment' (which we will shorten to 'ill-treatment' in this report, but is sometimes shortened to 'CIDT' in human rights literature). The lack of definition of ill-treatment in CAT reflects, in part, the lack of agreement described above relating to the practice of corporal punishment at the time that Article 1 CAT was being negotiated. However, a reasonable way to understand the relationship between torture and ill-treatment is that torture is a more severe form of ill-treatment, and that both torture and ill-treatment are at odds with international law. This view is confirmed by reference to the wording of Article 1.2 of the earlier 1975 Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, that 'torture constitutes an aggravated and deliberate form of cruel, inhuman or degrading treatment or punishment'. It is also confirmed by reference to Article 16.1 of CAT:

> Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article I, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.

As former Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak outlined, 'the words "which do not amount to torture" in Article 16 CAT indicate that torture is a particularly serious and reprehensible form of CIDT.'[46] Importantly, though torture and ill-treatment might be differentiated in international law, the absolute prohibition on these forms of treatment is consistent whether there is an act is torture or ill-treatment. This is confirmed above in Article 16 CAT, and also by the non-derogable obligation in Article 7 of ICCPR: 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.'

The absolute prohibition on ill-treatment is further confirmed by the Committee against Torture's General Comment that 'the obligation to prevent ill-treatment in practice overlaps with and is largely congruent with the obligation to prevent torture.'[47] This overlap is one reason that some scholars argue that in effect, there is no substantive distinction between torture and ill-treatment, and that insisting on a substantive distinction merely 'reinforces the misconception that cruel, inhuman, and degrading treatment causes less harm and might therefore be permissible under exceptional circumstances.'[48] This view has been affirmed by the recent revised United Nations Istanbul Protocol, which states that 'other forms of ill-treatment are also absolutely prohibited.'[49]

'Ill-treatment' as a concept highlights the relationship between dehumanising violence and the concept of human 'dignity'. This link is established within international law in different contexts, including in the common article 3 of the Geneva Conventions 1949, which problematise and prohibit 'outrages upon personal dignity, in particular, humiliating and degrading treatment.' The link between torture, ill-treatment and violation of human dignity is made transparent in the definition provided by Article 2 of the Inter-American Convention to Prevent and Punish Torture (1985) which states

> torture shall also be understood to be the use of methods upon a person intended to obliterate the personality of the victim or to diminish his physical or mental capacities, even if they do not cause physical pain or mental anguish.[50]

We discuss the concept of dignity and its relationship to restrictive practices in detail in section 1.2 below.

In summary, obligations to prevent torture and ill-treatment have several implications for use of restrictive practices. As above, in any setting, any forms of restrictive practices that satisfy the definition of torture under international law must be prohibited and immediately eliminated. Further, since an equal prohibition also applies to cruel, inhuman and degrading treatment and punishment, then forms of restrictive practices applied in any setting, which, while not rising to the intensity of 'torture' still represent ill-treatment, must be prohibited and immediately eliminated.

There are of course grey areas relating to what forms of restrictive practices might constitute torture and ill-treatment. However, guidance is available through a range of sources to identify uses of restrictive practices that are not in conformity with international law. For example,

Rules 43 and 47 of the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) provide guidance on use of restraint, including that 'instruments of restraint shall never be applied as a sanction for disciplinary offences.'[51] Further, in 2011 the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment has provided guidance on solitary confinement, its relation to social isolation, and when this practice constitutes torture and other cruel, inhuman and degrading treatment or punishment.[52] The recently published revised *Istanbul Protocol* provides guidance on investigation and documentation of torture and ill-treatment.[53] These sources of guidance assist to understand use of restrictive practices in a general sense, with a particular focus on their use in traditional sites of detention (that is, in police custody and prisons).

However, as indicated above, the definition of torture and ill-treatment is contextual, and must pay attention to ways these practices are used, in what setting, and against whom. For this reason, use of restrictive practices in health and disability support settings has been examined separately within an international human rights context, since arguably use of restrictive practices in non-criminal justice settings alters the 'purpose' of this sort of treatment. In this context, a growing scholarship has pointed to restrictive practices in health and disability support contexts being definitively at odds with international obligations to protect people with disability from torture and ill-treatment.[54] Perhaps most clearly, in 2013 the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment called for, in no uncertain terms that:

> It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions.[55]

The UN CRPD Committee has further clarified, in its guidelines on Article 14 CRPD, that:

> The Committee has called upon States parties to protect the security and personal integrity of persons with disabilities who are deprived of their liberty, including by eliminating the use of forced treatment, seclusion and various methods of restraint in medical facilities, including physical, chemical and mechanical restraints. The Committee has found that those practices are not consistent with the prohibition of torture and other cruel, inhuman or degrading treatment or punishment of persons with disabilities, pursuant to article 15 of the Convention.[56]

Both the Special Rapporteur's statement, and the CRPD Committee guidance is in conformity with emerging international human rights case law, including the Committee against Torture and the European Court of Human Rights.[57] It indicates a consensus at an international level that use of restrictive practices in health and disability support contexts is at odds with international law.

We note that above, the Special Rapporteur has defined restrictive practices as comprising 'coercive and non-consensual measures.' In some jurisdictions, there is a requirement that 'voluntary', 'informed' and 'current' consent be provided in order for restrictive practices to be authorised.[58] In many jurisdictions, regulations suggest that consent to restrictive practices may be provided, by the person subject to restrictive practices or by a person's guardian.[59] However, it is debatable whether 'consent' is possible for a 'coercive and non-consensual measure'. Certainly, this appears as a site of contention in relation to the human rights of people with disability.

First, it is important to note that generally within Australian jurisdictions, and with notable exceptions such as medical interventions, consent cannot be considered a defence in relation to the application or threat of actual or grievous bodily harm.[60] To an extent this resonates with the definition of torture and ill-treatment discussed above, which relates to forms of violence which threaten human dignity. In cases that threaten human dignity, the consent of the person may not be relevant for understanding whether an act constitutes torture or ill-treatment.[61]

Second, in relation to consent by a guardian, as indicated below, guardianship arrangements are at odds with the obligations under Article 12 CRPD to recognise people with disability as legal persons and 'provide access by persons with disabilities to the support they may require in exercising their legal capacity'. Where a guardian agrees to use of a restrictive practice, they are making a decision on behalf of another person to submit to a 'coercive and non-consensual' measure. This approach would certainly be at odds with the requirements of Article 12, and general obligation to protect people with disability from violence. It is also concerning that the structure of current regulations imply that if an NDIS service provider determines that a participant does not have the capacity to consent, then this can be a trigger for the appointment of a guardian in order to effect use of restrictive practices. This was highlighted in a recent Western Australia State Administrative Tribunal case, which pointed to the 'likelihood that more NDIS recipients will need to apply for guardianship orders, or for the amendment of guardianship orders, to expressly permit a guardian to consent to the use of restrictive practices.'[62]

Third, in relation to consent by a person with disability who is to be subjected to restrictive practices, while regulations indicate that consent must be 'current', the prior consent of the person with disability to a measure which would potentially be violent if concurrent consent was not provided, appears at odds with basic protections of individuals from violence. This is because, violence might be understood precisely as a 'coercive and non-consensual measure.' In this context, it is unclear what it would mean if the participant withdraws their consent at the time at which the restrictive practice is executed. Certainly, the direction of the law towards other infringements of bodily integrity, such as in the case of affirmative consent laws in relation to sexual activity, highlight that consent cannot be assumed based on a previous agreement to participate in an activity, and must be concurrent in nature. For example, recent amendments to the NSW Crimes Act 1900, make clear that 'consensual sexual activity involves ongoing and mutual communication, decision-making and free and voluntary agreement between the persons participating in the sexual activity.'[63] Advanced care directives provide one example

of a process where individuals can provide prior consent to a measure that compromises their bodily integrity. We note that there is, however, significant oversight over the use of such directives, including that they are focused on planning for end-of-life care.[64]

In summary, at least from a human rights standpoint, there is a high degree of uncertainty over whether prior consent to a restrictive practice means that it becomes a consensual measure as a result of that prior consent. This is because, first, it may not be possible to consent to an act that may lead to harm, second, where a guardian authorisation is used in place of consent, this would be at odds with international law, and third, prior consent to a restrictive practice is contrary to contemporary reform of law, which place emphasis on active and 'affirmative' consent. Certainly, the legal and human rights complexities – even impossibility – of a person with disability consenting to use of restrictive practices on them signals the dangers in relation to proposals for use of supported decision making (otherwise considered a means of realising Article 12 CRPD) being utilised to facilitate advance 'consent' to restrictive practices which are by definition contrary to human rights.

1.1.2 Protection from violence, abuse and exploitation.

CRPD contains several obligations to protect people with disability from violence, abuse and exploitation. At the centre of these protections are the 'overlapping' Articles 15-17 CRPD, namely: 'Freedom from Torture or Cruel, Inhuman or Degrading Treatment or Punishment', 'Freedom from Exploitation, Violence and Abuse' and 'Protecting the Integrity of the Person.'[65] These three Articles should be read in concert with Articles 12 to 20 CRPD, which, in an interlinked way, describe the rights people with disability enjoy to equality before the law, access to justice, liberty of movement, freedom from arbitrary detention and protection from torture, violence and exploitation.

These core civil and political rights carry obligations for immediate action. CRPD contains some obligations which intersect with economic social and cultural rights, and thus might conceivably be achieved 'progressively' over time depending upon societal resources ('progressive realisation' as a concept is articulated in Article 2 of the International Covenant on Economic, Social and Cultural Rights and article 4(2) of the CRPD). CRPD also spells out particular rights, such as the right to education (Article 24.2c), and the right to work and employment (Article 27.1i). However, many of the obligations contained in Articles 12 to 20 CRPD are core civil and political rights, and are thus intended to be implemented immediately. Certainly, the equal right of people with disability to protection from violence would be an obligation where immediate realisation is, at least in theory, demanded.

It is important to emphasise that the rights to equal protection from violence owed to people with disability are founded upon equal standing before the law and equal rights to access justice. Article 12 of the CRPD provides for equality before the law for people with disability, and specifically for equal recognition before the law. Realising equal recognition before the law involves people with disability having their decisions recognised on an equal basis with

others and being provided with the support they require to make decisions (also referred to as 'supported decision-making').[66] Underpinning Article 12 is 'universal legal capacity whereby all persons, regardless of disability or decision-making skills, inherently possess legal capacity.'[67] The right to equality before the law is a 'threshold right'[68] because having one's decisions legally recognised is necessary for the enjoyment of other rights, such as to liberty and independent living.[69] It is for this reason that, in their research report to the Disability Royal Commission, Kayess and Sands state that 'Article 12 is fundamental to the realisation of all civil, political, economic, social and cultural rights…[it]…is essential to the autonomy of people with disability, which is the first foundational Principle of the CRPD.'[70] Importantly, and of relevance to violence protection, Article 12 directly underpins Article 13 which articulates equal rights to access justice.

While the obligations to prevent torture and ill-treatment – reiterated in Article 15 CRPD – have been described above, it is worth highlighting in detail the obligations outlined in Article 16 CRPD relating to Freedom from Exploitation, Violence and Abuse. The full text of the Article reads:

1. States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.
2. States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive.
3. In order to prevent the occurrence of all forms of exploitation, violence and abuse, States Parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities.
4. States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.
5. States Parties shall put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

Article 16 CRPD has several implications for use of restrictive practices. Article 16.1 is wide in its breadth, and does not provide exceptions for the practice of some forms of violence, abuse and exploitation (such as those that are legally authorised, or which constitute crimes under domestic law). The broad obligation is for people with disability to be offered protection from violence, abuse and exploitation. Article 16.1, along with Article 16.2, recognise that violence, abuse and exploitation can occur 'both within and outside of the home', and thus potentially relates to use of restrictive practices and other violations that happen both within institutionalised and segregated care and support settings, but also more broadly in the community. Article 16.2 places emphasis on information, awareness and reporting; and Article 16.3 on monitoring processes within formal care and support settings. Relevant to potential justice and redress that might arise in relation to recent and historic experiences of restrictive practices, Article 16.4 places obligations on States to provide for 'recovery and reintegration' for victim-survivors. Article 16.5 establishes an obligation for States to take effective legal and policy steps to investigate and prosecute cases of violence, abuse and exploitation. Across all these parts of Article 16, the framers of the text have drawn attention to the need to pay attention to age and gender dimensions of violence against people with disability, recognising that exploitation, violence and abuse can have different implications for different people with disability.

Article 17 on bodily integrity outlines a concept that is implicit to the natural rights tradition, but not explicitly articulated within the other core human rights treaties, namely: ownership of oneself and one's body, and the right to freedom from arbitrary interference. This right to bodily integrity is implicit to core protections from violence, including freedom for torture, slavery, arbitrary violence, freedom of movement and freedom from arbitrary detention. Article 17 is one of the shorter Articles in CRPD, and to an extent, reflects the tensions that circulated in negotiation of the Treaty. However, Article 17 is 'the first time the concept of "integrity of the person" has been included as a standalone Article in a core United Nations human rights treaty.'[71]

To an extent, it is not accidental that this important right to bodily integrity was expressed explicitly for the first time in a specialist human rights treaty related to people with disability. Many people with disability experience the discriminatory application of routine non-consensual violations of bodily integrity, sometimes authorised by law. Relevant to restrictive practices, infringements of rights to bodily integrity remain 'one of the most critical areas of human rights violation for persons.'[72]

At first glance, Article 19 CRPD ('Living Independently and being included in the community') might not be considered immediately related to obligations to protect people with disability from violence. However, Article 19, read along with Article 14 ('Liberty and security of the person') and Article 20 ('Personal Mobility') substantially reorient one of the most fundamental civil and political rights: namely, rights to liberty and freedom from arbitrary detention.

Embodied in Article 19 is the fundamental principle 'that all human beings are born equal in dignity and rights and all life is of equal worth.'[73] However, the Article not only derives its force from a civil and political rights tradition, but seamlessly blends economic social and cultural rights in a way that means that 'Article 19 is one of the widest ranging and most intersectional articles of

the Convention.'[74] Indeed, in some respects, Article 19 represents a milestone in international human rights law, in that it seeks to comprehensively recognise the interdependence between the realisation of individual rights and the arrangement of institutions and society in general.

Key to Article 19 is that to realise liberty of person in a meaningful way, State and society resources will be required to enable individuals to live in a situation of their own choosing, and receive social support to achieve social, cultural, political and economic participation on an equal basis with others. Here, forms of institutionalisation and segregation are directly seen as a central problem. Institutions here are defined as sites where people with disability are denied control over living circumstances and prevented from participating equally in the community. In its General Comment on Article 19, the Committee on the Rights of Persons with Disabilities has provided strong guidance that 'institutionalisation' does not refer merely to large scale residential institutions, and can also manifest in smaller-scale settings such as group homes:

> It is not 'just' about living in a particular building or setting; it is, first and foremost, about not losing personal choice and autonomy as a result of the imposition of certain life and living arrangements. Neither large-scale institutions with more than a hundred residents nor smaller group homes with five to eight individuals, nor even individual homes can be called independent living arrangements if they have other defining elements of institutions or institutionalization. Although institutionalized settings can differ in size, name and set-up, there are certain defining elements, such as obligatory sharing of assistants with others and no or limited influence over whom one has to accept assistance from; isolation and segregation from independent life within the community; lack of control over day-to-day decisions; lack of choice over whom to live with; rigidity of routine irrespective of personal will and preferences; identical activities in the same place for a group of persons under a certain authority; a paternalistic approach in service provision; supervision of living arrangements; and usually also a disproportion in the number of persons with disabilities living in the same environment.[75]

Article 19 highlights that 'social exclusion also engenders stigma, segregation and discrimination, which can lead to violence, exploitation and abuse in addition to negative stereotypes that feed into a cycle of marginalization of persons with disabilities.'[76] Importantly, institutionalisation and segregation are connected with violence. In its reflection on the barriers to fulfilling the obligations of Article 19, the Committee groups together a number of factors, including the 'denial of legal capacity, either through formal laws and practices or de facto by substitute decision-making about living arrangements,' 'inadequacy of social support and protection schemes for ensuring living independently within the community' and 'physical and regulatory institutionalization, including of children and forced treatment in all its forms.'[77] The Committee also highlights the intersectional dimensions of this picture, for example noting that:

> Since institutions tend to isolate those who reside within them from the rest of the community, institutionalized women and girls with disabilities are further susceptible to gender-based violence, including forced sterilization, sexual and physical abuse, emotional abuse and further isolation. They also face increased barriers to reporting such violence.[78]

As such, the Committee has highlighted that institutionalisation and segregation impact different people with disability in different ways. Furthermore, as highlighted above, institutionalisation and segregation produce different outcomes in relation to protection from violence. We consider institutionalisation and segregation further in Chapter 4 of this report.

The above section demonstrates that the right of people with disability to protection from violence is fundamentally interconnected with realisation of several other core human rights. These rights include legal capacity, freedom from arbitrary detention and living independently in the community. This comprehensive approach to understanding violence experienced by people with disability is highlighted by Kayess and Sands in their research report for the Disability Royal Commission:

> Forced detention in a range of institutions, facilities and settings often leads to individual incidences of violence, abuse, neglect and exploitation and to medical interventions, behaviour management, restrictive practices and other 'treatments' that are applied to people with disability without their consent or with the consent of a substitute decision-maker. These practices violate the security of people with disability, the right to be free from exploitation, violence and abuse, and deny the right to provide free and informed consent in contravention of articles 12, 14, 16 and article 25, Health.[79]

As indicated in the above observation from Kayess and Sands, it is almost impossible to disentangle restrictive practices and forced treatment from a range of other human rights violations, including loss of legal capacity, and lack of access to independent living. Thus, while institutionalisation itself is not a restrictive practice, it is not an accident that the use of restrictive practices is associated with institutional settings. In this respect, the bundle of obligations contained in Articles 12-19 CRPD are interconnected, and they also connect with other obligations elsewhere contained in the Convention. As Chapter 3 and 4 of this report will detail, these factors form part of the 'ecological system' and drivers which lead to use of restrictive practices against people with disability.

In summary, in relation to rights of people with disability to protection from violence, abuse and exploitation, five observations can be made relevant to use of restrictive practices. First, even if some restrictive practices are not considered torture or ill-treatment, there remain strong obligations under CRPD 'to take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.' Second, certain parts of Articles 12-19 reflect civil and political rights and thus include obligations that are in principle immediate in nature (rather than progressively realisable). These Articles arguably places an onus on States and society to immediately end violence. Third, these obligations to protect people with disability from violence encompass actions to provide education, to monitor, to report and where appropriate prosecute those who carry out violence, abuse and exploitation. Fourth, what constitutes torture, ill-treatment and violence under international human rights is not limited to interventions that are recognised as crimes within a particular domestic jurisdiction, and thus can extend to interventions that are currently lawful and regulated by the State. Fifth, as indicated above, restrictive practices cannot be separated from a broader

context of legal and policy reform. This context of reform includes realisation of rights to equal recognition before the law, and the deinstitutionalisation mandate contained in Article 19.

1.1.3 Equality and non-discrimination

Equality is at the core of the modern human rights project. Indeed, many human rights express the relationship between rights to liberty and status equality in the exercise of these rights. This is summarised in the first Article of the Universal Declaration of Human Rights (UDHR): 'All human beings are born free and equal in dignity and rights.' Non-Discrimination principles express these equal treatment obligations. These principles were articulated with respect to the rights to equality before the law, equal protection of the law and the right to protection against discrimination in Article 7 of UDHR and Article 26 of ICCPR, and with more detailed definitions of the concept of discrimination being provided in treaties such as Article 5 of the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) and Articles 1 and 4 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and articles 2 and 5 of the CRPD.

Article 5 of CRPD reiterates the above obligations for equality and non-discrimination relating to people with disability. It is preceded by two Articles ("General principles" and "General Obligations") which also orient the Convention around 'respect for the inherent dignity of persons with disability, non-discrimination, and the full and effective participation of persons with disability in society,' and establish the basis for a program of change on ratification or accession.[80] While Articles 3,4 and 5 reinforce obligations to equality and non-discrimination, it is important to note that references to equality appear regularly through the text of the Convention.

The important of equality and non-discrimination in CRPD has been highlighted by the UN CRPD Committee in its General Comment on Article 5:

> Equality and non-discrimination are at the heart of the Convention and run like a golden thread through all its substantive articles via the phrase "on an equal basis with others". t links all substantive rights of the Convention to the non-discrimination principle. Throughout the ancient and contemporary history of the world, dignity, integrity and equality have been denied to persons with actual or perceived disabilities and discrimination has occurred in all its brutal and less brutal forms, including non-consensual and/or forced mass sterilizations and medical or hormone-based interventions (e.g. lobotomy, Ashley-treatment), mass murder called "euthanasia", , mutilation and trafficking in body parts, particularly of persons with albinism , and confinement. Despite progress in disability law and policy, persons with disabilities continue to be systematically excluded from many areas of life, often based on notions of dominance, power and devaluation such as racism, sexism and ableism.[81]

As indicated by the UN CRPD Committee, achievement of rights 'on an equal basis with others' is often the stated objective of each of the individual articles within CRPD. This objective highlights how equality is a central measure of the success of implementation of the Treaty.

For example, and relevant to the discussion above on Article 12, there is an obligation in the treaty that 'States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.' Here the measure of the achievement of people with disability of the right to enjoy legal capacity is comparative to the legal capacity enjoyed by others.

Article 5.2 of the CRPD calls on States Parties to 'prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.' Further, action against discrimination is demanded in a proactive sense within the CRPD. States Parties to the CRPD are not only obligated to respond and prevent discrimination, but also to engage in positive steps at the individual and structural levels to realise equality. In particular, there is an obligation to provide reasonable accommodation. The UN Committee on the Rights of Persons with Disabilities refers to this as an 'inclusive equality' approach.

These observations on the place of equality and non-discrimination within CRPD are important in relation to rights of people with disability to freedom from torture and ill-treatment, and to protection from violence. First, States and society have an obligation to ensure people with disability are not subject to torture and ill-treatment and have equal rights to protection from violence. Equal treatment obligations mean that failure to provide this protection to people with disability not only offends obligations to protect from torture, ill-treatment and violence, but also violates rights to equality, and by extension, violates rights to equality before the law, particularly where the law can be shown to not provide protection to people with disability on an equal basis with others.

Second, where people with disability are exposed on a discriminatory basis to forms of violence, including lawful violence, that are not applied to others, then this not only offends obligations to protect from torture, ill-treatment and violence, but also violates rights to non-discrimination. Recall here that CRPD applies the strong language in Article 5.2 that 'States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds. Here we can note that where restrictive practices are used on a discriminatory basis against people with disability – that is, their use in a range of settings against people with disability in ways that do not apply to others – then this use must be prohibited, as per Article 5.2 CRPD. As outlined in the Introduction to this report, the use of restraint and seclusion can be legally authorised in a range of contexts. For example, use of restraint and containment is a central element of the 'reasonable force' powers of the police that apply to members of the general population who come into contact with police.[82] In disability specific contexts, uses of restraint and seclusion are generally authorised by discrete policy and legislation, and are generally intended for use only against people with disability.[83] Under international human rights law 'not every differentiation of treatment will constitute discrimination, if the criteria for such differentiation are reasonable and objective.'[84] Further Article 5.4 CRPD states that 'specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention.' However, as this report will highlight, it is not

clear that the differential treatment of people with disability is reasonable or objective; certainly as described in Chapters 3,4 and 5 of this report, the use of restrictive practices is driven by institutional and segregated environments and lacks a strong evidence base to support their efficacy. Further, as shall be discussed below, the differential treatment of people with disability with respect to the use of restrictive practices undermines fundamental rights and injures the social status of people with disability.

It is precisely this discriminatory use of restrictive practices against people with disability that violates inherent rights to dignity, and thus is at odds with obligations under CRPD. We turn now discuss this concept of 'dignity', its importance within a human rights context, and its relation to restrictive practices.

1.2 Dignity

In section 1.1 above, we reviewed the international human rights norms and treaty obligations which relate to use of restrictive practices. As discussed above, many forms of restriction, where they relate to torture and ill-treatment, are prohibited under international law. Further, general obligations within the core treaties to protection of people with disability from violence suggests that forms of restriction, even where they are not clearly torture or ill-treatment, should be eliminated. Further, in so far as this violence is applied to people with disability on the basis of disability status, it also is at odds with obligations to non-discrimination under Article 5 CRPD. The concept of 'dignity' is threaded through many core human rights, and reflected in obligations to protect people with disability from torture and ill-treatment, as well as any form of discriminatory treatment. In this section we explore this important concept, and discuss its implications for understanding restrictive practices and their effect.

The concept of dignity can be understood in many ways. For example, dignity might be associated with how a person behaves, and the capacity of individuals to act or deport themselves in elevated, virtuous, or 'inflorescent' ways.[85] For example, we might observe a person dancing and based on their performance, attribute a 'dignity' to their actions to indicate that they performed in a way that demonstrates excellence. This use of dignity is of less direct relevance to contexts of violence, abuse, neglect and exploitation. However, it is worth noting that a failure to see excellence in other people may be interconnected with discrimination and stigma: for example, failing to recognise the academic achievements of a person because of the colour of their skin. Arguably, this is one of the impacts of ableism in shaping prevailing attitudes which prevent full recognition of people with disability.

A different example of use of dignity is related to so called 'dignity of risk.' Within disability policy contexts, the idea of 'dignity of risk' has often been used by advocates to argue for forms of self-determination or choice within the context of substitute decision making and guardianship.[86] However, where issues of the ability to exercise one's legal capacity arise, Article 12 CRPD mandates supported decision making in preference to substituted decision-making, and simultaneously emphasises meaningful choice and equal protection from violence, abuse,

neglect and exploitation. As Piers Gooding suggests, this implies a need for a shift away from a framing that is concerned with protection from risk, towards choice, information and equal protection from violence and abuse.[87]

The above understandings of 'dignity' are less useful for this report, although we engage further with the idea of 'dignity of risk' in Chapter 4. Instead, at this point in the report, and relevant to human rights protections from violence, there are two important ways in which dignity as a concept might be relevant to making sense of the violence and harms imposed by restrictive practices. First, dignity might be understood as an 'inherent' aspect of an individual that makes them worthy of respectful treatment. While the idea of inherent human dignity is essential to a variety of religious traditions, universal conceptions of inherent dignity – that is, that all humans are owed dignified treatment by virtue of their humanity – is most commonly associated with the enlightenment philosopher Immanuel Kant, for whom respectful treatment and inherent human dignity were at the core of ethics: 'act that you use humanity, whether in your own person or in the person of any other, always at the same time as an end, never merely as a means'.[88] Within moral philosophy, this view of dignity suggests that humans belong to a specific group, and that all members of this group, by virtue of their humanity, demand equal treatment. Daniel Sulmasy summarises:

> intrinsic dignity, the fundamental moral worth or value of a human being, is based upon nothing other than the bare fact that one is a member of a natural kind, that, as a kind, is possessed of these features. As such, intrinsic dignity is absolutely equal, inalienable, and does not admit of degrees.[89]

This commitment to recognition of inherent human worth through universally recognised dignity is a foundation of the international human rights project. It is expressed in Article 1 of the Universal Declaration of Human Rights (1948): 'All human beings are born free and equal in dignity and rights.' This fundamental right is reframed in Article 1 CRPD to make clear that the purpose of the instrument is: 'to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.' It is this inherent or intrinsic quality of dignity which informs the philosophical view that human rights are a special legal status, defined in a somewhat circular way as 'the rights that one has simply because one is human.'[90] We can leave aside the question of whether 'dignity' is only owed to humans, which is subject to some scholarly debate.[91] The main point is that 'dignity' evokes the social and legal status that humans essentially claim as a result of being human. It is thus this inherent dignity that is violated when persons are subject to torture and ill-treatment, arbitrary violence and discriminatory treatment.

There is a second and interrelated concept of dignity that is fundamental to human rights protections from violence. This is dignity as a form of status or rank that is recognized through how an individual is treated within the context of a social and political community. Jeremy Waldron highlights that this latter concept of dignity differs from ideas of intrinsic or inherent dignity because dignity is conceptualised in a way which is less about a quality that exists in the

person and should be respected. Instead, this second conception is concerned with the way in which individuals are treated, or the resources they are provided. In other words this second conception of dignity is concerned with what a person is entitled to:

> it is stated that humans have dignity and that this dignity inhering in the human person is the source and ground of human rights. And on the other hand, it is said that people have a right to dignity, or a right to have their dignity protected. In the former usage, dignity is presented as the ground of human rights; in the latter usage ''dignity'' is presented as the content of human rights, that is what the human rights are rights to.[92]

For Waldron, recognising that dignity implies ways of treating individuals in the context of a social and political community suggests that dignity is associated with a kind of 'rank'. For Waldron, the point of the human rights project was 'a sort of universalization, for all humans, of privileges that have historically been associated with particular ranks of nobility.'[93] This is a reminder of the classical origins of the word dignity. In ancient Rome, *dignitas* was not universal. Instead, *dignitas* was accorded to Roman citizens, a select group of individuals who had rank and authority.[94] This rank came with privileges, including, as discussed below, freedom from certain forms of dehumanising violence. Human rights universalise and democratise respectful treatment, and thus innovate in seeking to ensure that all humans, rather than just a select few, are treated in ways that maintain an agreed basic status or rank.[95] Further, this conception of dignity is *positive* in nature, as society, its resources and actions establish the conditions under which dignified treatment becomes possible.

It is certainly possible to combine the two ideas of dignity described above together in ways which both suggest that individuals have inherent dignity, but also that society has a role in creating the conditions where dignity might be realised. This combination is apparent in capabilities approaches to justice, which highlight that societies have the responsibility to create the conditions by which individuals can have their inherent dignity recognised and be provided resources so that they can function and flourish. Martha Nussbaum states:

> Some living conditions deliver to people a life that is worthy of the human dignity that they possess and others do not. In the latter circumstance, they retain dignity, but it is like a promissory note whose claims have not been met.[96]

Nussbaum's description of dignity is very useful for interpreting the rights people with disability as articulated by CRPD. Indeed, as Theresia Degener notes, CRPD innovates by making clear that impairment does not remove human dignity from people with disability. As Degener notes, CRPD is not only built on the 'premise that disability is a social construct, but it also values impairment as part of human diversity and human dignity.'[97] Thus, on one hand, CRPD affirms the fact that people with disability have inherent dignity, and like other humans, are owed rights. On the other hand, the Convention creates a program for action in the many areas of social, political and cultural life where people with disability are owed treatment worthy of human dignity, and governments and societies have responsibilities to provide adequate resources to

enable this respectful treatment to be realised. CRPD thus both recognises that people with disability have inherent dignity and simultaneously outlines the program of work required to elevate the status of people with disability in our societies.

These two ideas of dignity – as indicating inherent worth, but also as a rank or active entitlement – are highly relevant to human rights to protection from violence, abuse, neglect and exploitation. One reason is the centrality of 'dignity' as a concept in understanding violence in a broad sense, and torture and ill-treatment in a particular sense. Today, as discussed in section 1.1 above, there is an absolute human rights prohibition on torture and ill-treatment, and strong obligations to prevent violence. These rights and obligations should apply to all humans everywhere. However, these rights to freedom from violence were not always understood as universal in nature. As discussed above, in ancient Rome, rank or status operated as a protection from dehumanising forms of violence. In that context, dehumanising forms of violence included the use of torture to illicit confessions, or horrific forms of corporal punishment such as whipping with *flagrum*, or capital punishment such as *damnatio ad bestias* (being thrown to beasts) and crucifixion.[98] These forms of violence were reserved for slaves and outsiders; citizens claimed protection. Thus, as Darius Rejali discusses, the Roman citizen claimed a rank or dignity which effectively provided 'civic immunity from torture.'[99] Further, as Rejali underlines, we inherit concepts of humane and inhumane violence from ancient political communities where those who were excluded from civic membership of the community were considered as not human, and therefore not protected from some forms of violence which would be 'dehumanising':

> What do we mean when we speak of humane violence or humane punishment? What we mean at the very least is that we treat humans differently from nonhumans when applying violence. The Greeks and Romans understood the matter in this way as well. Nonhumans could be tortured and crucified, but humans were not supposed to be treated that way. A great deal, then, turns on who is or is not human. For their part, Greeks believed one was not a full human being if one did not live in a free polis or a republic. So, for them, treating barbarians inhumanely was unproblematic. Within a polis, humans achieved their highest potential as self-governing citizens. But not everyone in a polis was a citizen, and treating these people inhumanely was not problematic either.[100]

Here, those who have been granted full citizenship are owed humane treatment, while nonhumane forms of violence are deemed fitting for those who are imagined lacking the full dignity of the citizen. In this case, a conception of assumed inherent dignity determines the kind of violence that individuals will experience. In ancient Greece or Rome recognition as a citizen (or 'human') was purely discriminatory. Typically, slaves, women and outsiders did not enjoy the status of citizens, and thus were potentially subject to inhumane violence. Recognition of dignity is defined by the freedom not to be subject to undignified treatment.

Another aspect of inhumane violence is that, in an active sense, it removes dignity from its recipient. Here, we see that this violence is not exercised simply because of a failure to recognise the inherent dignity of its recipient, but, in active sense, the treatment of the individual is designed to remove their dignity. All violence potentially dehumanises.

However, torture and ill-treatment, almost by definition, strip their recipients of dignity through a process of dehumanisation.[101] This stripping of dignity was the point of the horrors of public torture and execution. These public forms of violence actively scarred and broke the body, and if their victim survived their torment, they would always carry the social stigma of this violence as a reminder of their devalued social status.[102] In some cases, as in the case of racial slavery, such uses of violence participated in forms of racialisation which marked those who were subject to it to forms of continuing 'social death.'[103] This violence thus works in an active sense to 'produce' those who are not provided rights to participation or equal recognition. It is for this reason that Rejali argues that torture is a 'civic marker', in so far as it is a tool of social stratification.[104]

In summary, dignity is an important concept within human rights conceptualisations of rights to protection from violence, torture and ill-treatment. Relevant to restrictive practices, we might observe the following. First, as discussed in Section 1.1, some forms of restrictive practices are considered as torture and ill-treatment under international law. Further, even where forms of restriction are not considered to rise to a threshold of 'torture or cruel, inhuman degrading treatment or punishment,' the fact that they are applied on a discriminatory basis towards people with disability means they are at odds with obligations to ensure non-discrimination and equal rights to protection from violence. The fact that these practices continue to occur represents a failure of the law to recognise the inherent dignity of people with disability. That is, they fail to recognise 'the inherent dignity and worth and the equal and inalienable rights of all members of the human family as the foundation of freedom, justice and peace in the world.'

Second, restrictive practices, in so far as they involve violence, torture and ill-treatment applied on a discriminatory basis towards people with disability, participate in the stripping of the dignity specifically of people with disability. Restrictive practices cannot equally be available to strip the dignity of people without disability, and thus participate in the dehumanisation and stigma that people with disability experience in our societies. As such restrictive practices as they currently occur operate as a 'civic marker', which actively removes dignity and devalues the status of people with disability. In other words, our societies devalue and dehumanise people with disability in a variety of ways, the legally and institutionally validated use of restrictive practices is one important way in which the social status and rights of people with disability are injured.

1.3 Summary

International human rights norms and laws provide guidance in relation to use of restrictive practices. In summary, we observe the following six points of guidance relating to restrictive practices and the human rights of people with disability.

First, in so far as restrictive practices are torture or ill-treatment, there is an absolute prohibition on their use under international law. While there may be uncertainty over whether some practices might be considered torture or ill-treatment, the guidance from the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment provides clarity. Although not in itself legally binding, this guidance indicates that 'it is essential that an absolute

ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions'.[105]

Second, even where restrictive practices might not be examples of torture or ill-treatment, the strong requirements in CRPD to take steps to protect people with disability from 'all forms' of violence and abuse mean that use of restrictive practices are in general at odds with these obligations, and the obligations of States and society to protect rights to access justice for those are subject to these practices. States and society also have strong obligations to protect age and gender specific groups of people with disability from violence. The use of restrictive practices is at odds with these requirements.

Third, the discriminatory use of restrictive practices against people with disability, primarily authorised through legislation that allows for differential treatment, is at odds with the strong obligations in CRPD to 'prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds'. The continuation of these practices as a form of discriminatory treatment, and the legality of these practices through disability-specific legislation, jurisdictions, and tribunals violates rights to equality before the law and equal protection of the law, as outlined in Article 5 CRPD and Article 26 ICCPR.

Fourth, restrictive practices, in so far as they involve violence, torture and ill-treatment applied on a discriminatory basis towards people with disability, participate in the stripping of the dignity of people with disability. Restrictive practices thus participate in the dehumanisation and stigma that people with disability experience in our societies.

Fifth, CRPD itself points to the reality that the drivers for violence against people with disability, including restrictive practices, are interconnected with multiple rights violations. CRPD recognises these drivers as including the failure to recognise and support legal capacity and the failure to ensure that people with disability can enjoy rights to live independently in the community on an equal basis with others.

Lastly, at the core of human rights obligations to prevent torture and ill-treatment, protections from violence, and equality and non-discrimination, is the principle of dignity. Use of restrictive practices fail to respect the inherent dignity of people with disability. Further, these practices might be understood as stripping dignity from people and undermining their status, thus exacerbating their inequality, which in turn exposes them to further violence. In other words, as previously stated, our societies devalue and dehumanise people with disability in a variety of ways, the legally and institutionally validated use of restrictive practices is one important way in which the social status and rights of people with disability are injured. In the next chapter we bring texture and contour to this statement, amplifying the voices of people with disability and those closest to them to articulate the lived experiences of restrictive practices and denial of dignity.

Chapter 2: Experiences of restrictive practices

The Disability Royal Commission has a focus on understanding 'the specific experiences of violence against, and abuse, neglect and exploitation of, people with disability'.[106] As such, this report foregrounds the voices and experiences of people with disability who have been subject to restrictive practices. This means this chapter is based in the expertise of people with disability's lived experience, enabling the voices of people with disability who have been subject to restrictive practices to speak for themselves. While the experiences of professionals and service staff are also explored in this report (particularly in Chapters 4 and 5), the project's disability human rights methodology necessitates that highest priority is given to people with disability, and particularly to listen to and learn from individuals with disability who have experience of restrictive practices.

The chapter comprises six main sections. Each section attends to one of the core, common experience of restrictive practices articulated by people with disability. In the first section, the chapter provides examples of the immediately felt trauma – that is prolonged pain, harm, and violation – experienced by some people with disability who have been subject to restrictive practices. In the second section, the chapter amplifies stories of abandonment and neglect. In the third, the chapter attends to people with disability's experiences of fear and terror associated with use of restrictive practices. The fourth section of the chapter presents accounts of disempowerment, dehumanisation and degradation. The fifth section considers people with disability's experiences of restrictive practices as cruel, and as something that is akin to, but at times also experienced as 'worse than', punishment in the criminal justice system. Lastly, the sixth section describes some of the lifelong trauma and life-altering effects that restrictive practices pose for people with disability, and their sense of self and identity.

Before moving into some of the first-hand experiences of restrictive practices provided by people with disability, it is important to note that this chapter, while based on a significant collection of data, is not intended to provide generalisable findings about what all people with disability might experience when subjected to restrictive practices. As explained in the Introduction Chapter of this report, our approach to data collection did not include a large sample survey, so the results we present here cannot be generalised. Additionally, the data we did collect – which comes from scholarly literature, reports, government inquiries, and the submissions that have been made to those inquiries – has limitations. For example, there has been little scholarly research or government inquiry conducted in the Australian context into the experiences of people with disability subject to restrictive practices. For this reason, it has been necessary to include the experiences of people with disability who live in other comparable countries within our report. There has also been almost no research or inquiry conducted into the experiences of restrictive practices for LGBTQIA+ people with disability, or culturally and linguistically diverse people with disability, and only a few studies consider the experiences of First Nations peoples with disability. Additionally, while people with disability's experiences of some forms of restrictive practices are well explored – such as experiences of seclusion or involuntary mental health treatment – experiences of other forms of restrictive practice such as guardianship or financial management are rarely considered.

Perhaps the most apparent, and arguably telling, limitation affecting this report, is the disparity between the number of accounts of restrictive practices sought in past research from people with different types of disability. Put simply, the voices and experiences of people with psychosocial disability have been captured in far more inquiries, reports and research than the voices of people with almost any other type of disability. This disparity in accounts is at least in part reflective of the opportunities that have and have not been provided to people with different types of disability to articulate experiences of restrictive practices over the years. Very few researchers venture into group homes to speak with people with disability. Likewise, to the best of our knowledge, few, if any, attempts have been made to capture the accounts of people with disability subject to restrictive practices in the context of Australian Disability Enterprises, day programs, out-of-home-care, immigration detention, and in the family home. Similarly, while there has been increased focus on restrictive practices (notably chemical restraint) in residential aged care facilities, this focus has largely been from the perspective of care partners and family members rather than people with disability. The voices of people living with dementia are notably absent in much residential aged care research. Finally, although restrictive practices in school settings have garnered increased attention in recent years, for the most part, it remains parents who are enabled to speak on behalf of their child about their child's experiences. While many parents of children and young people with disability are fierce advocates, offering important insights into the impacts of restrictive practices, a parent's testimony is not the same as that of the person who experiences this violence. More work needs to be done to fully capture the range of experiences of restrictive practices of diverse, intersectional, disability communities in Australia. We note that these limitations impact the ability of the report to respond with strong specificity in relation to relevant research questions (RO1, RQ2 and RQ3) on observed differences between type of disability, type of restrictive practice and/or type of setting.

2.1 Pain, harm and violation

In the scholarly literature, reports and submissions we analysed, numerous examples were provided of people with disability articulating the complex and multifaceted nature of the violence and trauma they experienced when subject to restrictive practices. While there were a range of different words used by people with disability to articulate and express the nature of this trauma, most accounts centred around three core experiences: pain, harm and violation. Notably, a focus on pain associated with restrictive practices – either physical or mental – is relevant to consideration of the human rights implications of their use. As discussed in Chapter 1, restrictive practices are at odds with several human rights obligations, including importantly, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT). Torture under international law is understood as:

> any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the

> instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.[107]

We are not in a position to verify the existence, severity or duration of physical and mental suffering described by individuals in the experiences outlined below. Nor are we in a position to specify which restrictive practices cause pain from these accounts. However, any suffering associated with restrictive practices provides grounds for serious consideration in light of obligations to prevent torture and ill-treatment.

Experiences of pain were often raised in discussions with people with intellectual and/or developmental disabilities. Indeed, in the experiential data we collected from past research, people with intellectual and/or developmental disabilities would often speak clearly about the pain they experienced at the hands of those who are meant to provide them with services and supports. For example, one person with disability in a UK study of seclusion, restraint, and rapid tranquilisation of people with developmental disabilities said:

> It really hurts.
>
> Stretching my legs apart, my poorly leg.
>
> It's cold in there. They've got no heating in there at all.
>
> Make my throat go all funny.
>
> It would broken my legs.
>
> It bloody hurts.[108]

Similar sentiments of pain and being hurt were expressed in a research report that was commissioned by the Office of the Senior Practitioner in Victoria into the experiences of restrictive practices by people with intellectual disability in that state. In that research, four skits of different restrictive practices were used by the research team to elicit responses and reflections from people with intellectual disability. The people with intellectual disability involved in the research were shown the skits, and then encouraged to respond to what they had seen. They were also asked to discuss if they had personally experienced or witnessed such interactions before. Skit 4 involved a scenario where a resident of a group home is shown walking into a room and hitting a co-resident. In this scenario, staff from the group home run into the scene and physically restrain the first resident. That resident is physically held back and then wrestled to the ground and held again. When the people with intellectual disability involved in the research were asked if they had ever experienced the type of restriction they saw in the skit, several indicated that they had, and articulated the pain that this caused them. One person with intellectual disability explained their experiences of this kind of restrictive practices as follows:

> [Staff] Tied a sheet around my neck and dragged me out the door. It wasn't any good.[109]

While another person with intellectual disability explained:

> Someone [staff] kicked me on the leg and hit me like that [demonstrates]. Punches to the stomach. It was wrong. It was nasty. Awful.[110]

Both accounts by people with intellectual disability arguably meet the threshold of assault as per criminal law. We note, however, that each account was given in response to a question about experiences of physical restraint. To this end, both accounts, along with the third presented above, begin to give voice to some of the physical pain associated with being subject to restrictive practices, and the associated use of coercive and non-consensual measures.

Some of the other accounts collected in the material we analysed articulate some of the mental and emotional harms associated with being subjected to such violent actions. For example, in the recent Royal Commission into Victoria's Mental Health System, a person with psychosocial disability said:

> In all of my compulsory admissions I was restrained, and in two admissions I was secluded as a way of protecting me from the dangerous behaviour of other male patients … Seclusion and restraint were incredibly counterproductive and damaging for me.[111]

These kinds of sentiments of restrictive practices being harmful and counterproductive are well documented in the broader international literature. For example, in a US study of people with psychosocial disability's experiences of acute psychiatric hospital, one woman described her experience as follows:

> I felt violated … I felt everything had been stripped from me … I felt ashamed.[112]

Similarly, another person with psychosocial disability who experienced restrictive practices in the Canadian mental health system expressed:

> It was harmful to my whole being, an assault on my dignity and attack on my soul.[113]

And, Charlie, another person with psychosocial disability explained in the context of experiencing physical restraint in an inpatient psychiatric service in the UK:

> [I felt] violated in some way, mistreated and abused.[114]

Another person from the same UK study, Bob, also described their experience of restraint as violation:

> I don't like being pushed and poked … but all they were saying was grab his glasses, drag him out and all that … They said we all need to grab him out, grab him out … It was just the staff like manhandling me basically … I felt violated in a way.[115]

Speaking about restrictive practices as violation, an assault on dignity, and as an attack on the soul, are strong words. As discussed in Chapter 1, conceptions of dignity inform rights to freedom from violence. When people are subject to torture, ill-treatment or discriminatory violence, then this both fails to recognise the inherent dignity of the person and simultaneously devalues the status of the person who receives this violence. In this sense, it is not surprising that restrictive practices should be understood as an attack on dignity. These words help to articulate just how traumatic the experience of restrictive practices can be for some people with disability.

What is important to understand about the traumatic nature of restrictive practices, however, is that this trauma is rarely experienced as a singular, one-off experience. Indeed, as another person with psychosocial disability made clear to the Royal Commission into Victoria's Mental Health System, restrictive practices are often used daily, or at least, repeatedly. This dynamic of repetition, compounding violent, painful and harmful interventions in people's lives, contributes to the trauma that is experienced. As the person with psychosocial disability explained to that Royal Commission:

> I was in the mental health system but was diagnosed with an eating disorder only two years later … I was traumatised because every day my treatment consisted of security, restraints and a nasogastric tube.[116]

Crucially, for some people with disability, the trauma they experience from being subject to coercive, non-consensual and harmful interventions in their lives intersects with, and is at times compounded by, other dynamics of oppression and injustice. For example, Sambrano and Cox's 2013 study of First Nations peoples subject to seclusion in mental health services gave voice to the ways that many First Nations peoples experience restrictive practices in mental health services as continuous with, and connected to, settler-colonisation, and the discriminatory and degrading treatment experienced by First Nations peoples at the hands of governments, police and health services.[117] In Sambrano and Cox's study, Daniel, a First Nations person with psychosocial disability spoke in the following way about his experience of being hog-tied by nursing staff in a mental health service:

> And there was one time they hog-tied me. They got me on the ground and put my legs and arms up behind me and held me down. It was kind of like being hog-tied. That was very distressing coz I couldn't breathe normally when I was under a lot of pressure … I think the nurses, when it comes to seclusion, they are very heavy handed. When it comes to putting someone in seclusion … the nurses hold you, you've got your arms behind your back or they hold your clothes. It feels like you want to break free but you can't. And the nurses won't let you go. That's why it feels heavy handed. Coz you're trying to break out of it but they won't let you go.[118]

While Daniel's account speaks to the physical and psychological trauma of the experience – feeling like you want to break free, but you cannot – it is important to recognise that for First Nations peoples, there are other harms associated with restrictive practices that go to the dispossession and displacement of First Nations peoples from Country. For example, the 2014

Seclusion and Restraint Project Report of the Melbourne Social Equity Institute included the following reflection by a carer of a person with psychosocial disability, they said:

> Could I put another perspective on – another form of restraint and isolation is … when traditional aboriginal people are brought down out of their country, and placed in an environment that's totally alien to them, so on top of their mental illness issue they're out of context, they're out of country, they could be in the middle of an exercise yard, but they're still restrained, they're still totally isolated because they can't connect, and that's one of the ones I think it's more a prison issue, but also it folds over into the mental health issue as well.[119]

Other intersections between restrictive practices and the oppression and injustice experienced by some people with disability have been raised in accounts of women with disability. A 2020 Australian study of gender-based violence in mental health inpatient units, for example, offers several accounts of women with psychosocial disability describing gender-based violence perpetrated by male staff members employed at mental inpatient units. The gender-based violence described by these women with disability occurred in the context of treatment. One woman, Elizabeth, shared the following account in that report:

> There was a stage there where they forcibly removed my underwear … They were worried about my safety because I was facing seclusion, I spent 27 hours in seclusion … It made my behaviour worse so I tried to kill myself in that unit, in that seclusion room … I have flashbacks of [the restraint] and the removing of my underwear and it's just – I just can't seem to move past it but at the same time I'm stuck 'cause I don't want to reach out to anybody 'cause I'm worried that all this stuff is just going to happen all over again.[120]

Amanda, another woman interviewed as part of the study into gender-based violence in Australian mental health inpatient units, recounted the following experiences:

> I've survived a lot of trauma and assaults in the past and rapes in the past and it was like what they did was repeating the trauma of that because they tackled me to the ground, they pinned me on the ground and then they basically forced me into a room that I didn't want to be in with security guards who were threatening to sexually assault me and who were just standing over me and glaring at me and saying abusive things to me in the doorway.[121]

Similar accounts by women in mental health inpatient units have been found in other countries. A 2017 study by Fish and Hatton, for example, investigated the gendered experiences of physical restraint on locked wards for women in the north of England. In the following excerpt from that study, Kate, a woman with intellectual disability, alludes to a connection between restrictive practices and gendered violence and/or sexual violation:

> Kate: It made me feel awful because when I was restrained my top come up a little bit, OK it was only my belly showing but that's bad enough. I'm a woman, I was being restrained by three men. Yes, there was two women and three men. And there was other men in the room making sure that I didn't attack anyone whilst being restrained.

> […] Researcher: Did it make you more angry?
>
> Kate: Yes. It would anyone knowing your body was on exposure and you didn't want it to be. It made me worse and I was actually trying to get them off me so I could [pull top down]. I were trying to bite, everything … It happened [in named service], that my pants were half way down my legs and one of my staff, I was saying 'Pull my pants up' and she goes 'No-one wants to look at you anyway, you're a fat fucker.' One of the staff.[122]

In the same study, Annie, another woman with intellectual disability gave voice to the ways that having men involved in restraint of women is not simply traumatic for the woman involved, but can also contribute to ongoing use of, and perceived need for, restrictive practices. Annie explained:

> They've got it down to where I could only be restrained by females and that helped because I started getting restrained less more and when I did get restrained I wasn't fighting as much and I wasn't having injections as much, I wasn't going in seclusion as much.[123]

The cycle of use of restrictive practices and behaviours that are perceived as being obstructionist, difficult or 'challenging' is something we return to in greater detail when we consider the broader ecological system surrounding use of restrictive practices in the next chapter (Chapter 3). For now, we simply note this important intersection of traumatic, violent actions, and gendered oppression, that can circulate in use of restrictive practices. We also note that while the above accounts by Olivia, Amanda, Kate and Annie speak to some contours of the gendered experiences of physical restraint, the literature has captured accounts of some men with disability speaking to similar experiences of violation. In a study of seclusion in a forensic psychiatric inpatient setting, for example, Ali describes his memory of staff observing him in the shower as follows:

> I felt like I was being like, visually abused or something. It didn't feel, feeling right at all.[124]

2.2 Abandonment and neglect

Experiences of abandonment and neglect were a second common theme presented in the experiential data we collected from past research. In bringing these two terms together in this section of the chapter we note that neglect is often associated with an omission or failure to consider a person's needs, while abandonment is perhaps better understood as a more conscious act associated with casting an individual outside the realm of safety and care.

Perhaps indicative of the nature of both neglect and abandonment, most of the accounts we identified in the experiential data had been provided by people surrounding people with disability, not the person with disability themselves. Thus, for example, a parent of a child with disability articulated the following scenario in which children with disability's experience of restrictive practices intersects with experiences of abandonment and neglect:

> Sometimes I see children locked outside of the classroom in a penned off area with no adult supervision. There are children in my son's class who they put in restraints on chairs who have little or no speech and no physical disability. I have talked to the child's parents when I see this and they have asked the school not to do this, but sadly they continue to do it every day.[125]

As the parent describing the above scenario articulates, what is problematic about the school's interaction with children with disability in the above scenario is not simply that the school is subjecting several children with disability to a variety of restrictive practices – from being locked outside of the classroom, to being penned off in an area, and to the use of mechanical restraints on chairs. Rather, what is also of concern here is that these harmful interventions in these children's lives often occur in a context of neglect and disregard of needs. These harmful interventions take place every day without adult supervision, without regard to requests for this to stop, and in neglect of the child's educational needs.

It is important to understand, however, that the abandonment and neglect people with disability experience when subject to restrictive practices is not simply about the absence of a 'responsible' person. Indeed, as the following account by an advocate for people with disability makes clear, simply having a 'responsible' person present does not negate the experiences of abandonment and neglect that people with disability can still be subject to in the context of restrictive practices, nor the harmful consequences associated with being cast aside and having needs ignored while subject to restrictive practices:

> A child with autism was restrained by teachers and locked in a time-out room for more than an hour, and despite instructions that he was to be checked on after 3 minutes, a teacher standing outside the room ignored him, during which time he wrapped an electrical cord around his neck.[126]

While the above two examples of abandonment and neglect focused on school-aged children, the intersecting experiences of abandonment, neglect and restrictive practices are not specific to people with disability of this age. Indeed, in the sixth Public Hearing of the Disability Royal Commission, Dr Manya Angley, a consultant pharmacist from South Australia, provided three deidentified case studies of adults with disability who were subject to the intersecting experiences of abandonment, neglect and restrictive practices. While none of the three case studies provided are told by the person with disability in question, each provide insight into some of the complex intersections of abandonment, neglect, restrictive practices and harm that are visible to an outside observer. We consider two of these case studies below, beginning with the first:

> The first patient was an autistic person living alone in supported care in the community. Despite having no psychotic illness, this patient was prescribed an antipsychotic at an average maintenance dose for psychosis, as well as two anticonvulsants and PRN benzodiazepine in the absence of any approved indications or diagnoses. The patient was experiencing side effects from the medication including weight gain, tremor and headaches, with no evidence of there being any monitoring of toxicity or regular blood tests.[127]

Dr Angley's account of the first case study offers three connected insights. First, this case study speaks to the ways that some people with disability can become subject to chemical restraints in the absence of approvals (although, see Chapter 5 for an extended discussion of some of the problems associated with distinguishing 'authorised' and 'unauthorised' uses of restrictive practices). Second, Dr Angley voices some of the bodily harms that this autistic person is experiencing because they are subject to restrictive practices: the person is gaining weight, and has tremors and headaches. Lastly, this case study speaks to the broader environment and experience of neglect and abandonment. No one is monitoring the harms that are being done to the autistic person in question. No one is attending to that person's needs.

A very similar scenario plays out for another person with disability in the third case study provided by Dr Angley in the same Public Hearing. In that third case study, Dr Angley explains:

> The third patient was a person with an acquired brain injury and intellectual disability. This person had been prescribed the maximum dose of risperidone used for the treatment of psychosis, even though he had not been diagnosed with psychosis. Dr Angley said there had not been appropriate monitoring of the person's medication and they were experiencing adverse effects such as hyperglycaemia and akathisia (restlessness or agitation).[128]

Once again, what we can gain from these observations of Dr Angley are insights into use of restrictive practices, the harms they cause people with disability, and the lack of consideration and attention (i.e., neglect and abandonment) that surrounds these experiences of harm.

As previously stated, it is perhaps indicative of the nature of abandonment and neglect that most of the accounts identified in the data we collected from past research were voiced by individuals associated with a person with disability, not the person with disability themselves. Put differently, when children with disability are locked up in penned off areas without adult supervision, or supervised by adults who ignore their needs, or when adults with disability are experiencing harmful, unwanted and unrequested bodily changes that no one else appears to consider or pay attention to, it is not surprising that we don't hear directly from these specific people whose voices, needs and desires are being ignored. Where we do hear some of these voices, however, is in the context of people with psychosocial disability who have previously been subject to restrictive practices in a mental health setting, but who are, at the time of their interview, not currently subjected to restrictive practices. What we gain from listening to these voices of people with psychosocial disability are insights into some of the emotional and psychological experiences of abandonment and neglect that restrictive practices precipitate. These experiences are brutally captured in the following account by Jay, who has experienced seclusion in a forensic psychiatric setting:

> I just remember being really distressed … Makes you more, made me more, determined that, I'm really on my own. And, seems no matter where you get put for care, ultimately, there is no help. It just feels totally like, abandoned, helpless.[129]

While Jay articulates a range of emotional and psychological harms associated with the abandonment and neglect of restrictive practices he experienced – feeling abandoned, helpless, like there is no help and you are ultimately on your own – feelings of abandonment and neglect have also been captured in some studies through the simple word 'left', as the following account by another person subject to seclusion illuminates:

> [I was] left in a seclusion room for a week without my clothes. I shit up the walls.[130]

And, as further elaborated in the following account by another person subject to seclusion in a mental health setting:

> Sweeping them all under the carpet, it's easier to not deal with you and your problems, even though that's the only reason you're here, is to have somebody help you deal with yourself and your problems, so instead of doing that for you we're just going to sweep you under the rug and put you in a cell that has no toilet and no air and leave you there for ten hours and then you'll be cured, and it's not – you go in there seeking help and surviving the traumas in your life, but you end up having to cope with even more trauma. It's pointless.[131]

Importantly, as we now explore separately and additionally below, for some people with disability, these experiences of abandonment, neglect and trauma contribute to, and become enmeshed with, experiences of fear and terror.

2.3 Fear

Experiences of fear appeared in many of the first-person accounts of restrictive practices we collected from the literature. Typically, these articulations came from people with psychosocial disability who were subject to seclusion. For some people with disability, fear manifests in relation to the brutality of their experience of seclusion itself, and from the related experiences of abandonment and neglect, as Kate explains:

> It were awful because it's bare walls. There's nothing in there. Nothing in there. They even took the mattress off me because some clients will put the mattress against the door so you can't see in. And they didn't want me doing that so they took the mattress. So I sat on a wooden bench, basically it's harder than [wood] because it's reinforced […] I was really scared I actually peed myself through being frightened. I wet myself![132]

In other accounts of seclusion, the fear described comes from a sense of not knowing what will happen next, and, importantly, not feeling safe enough in the setting to believe that what *could* happen next would be anything other than more violence and harm:

> every time they open the door, they kinda like all in gloves and there was about 12 of them, I thought, what the fuck's going on here, that's why I was getting you know like ideas in my head thinking they're gonna fuckin' kill me.[133]

Notably, some people with disability described these feelings of fear and not feeling safe in mental health settings as being linked not just to specific moments of seclusion, but also to the operation of the whole ward. As the following person with psychosocial disability put it:

> there's just a whole terror culture on the wards ... there's a lot of fear about it ... it's a fear culture, which is still operating.[134]

We return in Chapters 3 and 4 of this report to explore some of the workplace cultures and considerations that sit within the broader ecological system of restrictive practices for people with disability. For now, we note that in the case of this person with psychosocial disability, experiencing this 'fear culture' – which includes moments of restrictive practices, but which also includes a broader ecological system of 'terror' – had a long-lasting effect. As they explained:

> It left me with total fear of the whole of the mental health service people ... that will always stay with me.[135]

Very similar sentiments were expressed by another person with psychosocial disability in the recent Royal Commission into Victoria's Mental Health System. That person explained:

> Being in seclusion was incredibly distressing for me. My borderline personality disorder is pronounced when I'm psychotic, and I will often experience intense feelings of abandonment and intense suicidality. While I was in seclusion, I felt abandoned and suicidal. As a result, I have about 20 different suicide plans about how to end my life in preference to being back in a public mental health unit. I am in fear for my life if I have to go back to a public hospital.[136]

We return in section 2.6 below to consider some of the long-lasting effects of restrictive practices for people with disability, including those described in the above two accounts. For now, we note that these accounts, alongside those presented before them, offer insight into the range of ways that people with disability experience fear in the context of restrictive practices, and especially in the context of seclusion. We further note that these experiences of fear often contributed to, and became enmeshed with other experiences of restrictive practices, such as experiences of disempowerment, humiliation and dehumanisation. We describe experiences of disempowerment, humiliation and dehumanisation in greater detail next.

2.4 Disempowered, humiliated and dehumanised

One of the most repeated sets of experiences of restrictive practices that emerged from the data we collected from past research was that of disempowerment, humiliation and dehumanisation. For some, like the following person with psychosocial disability, feelings of powerlessness are considered to be the worst part of being subject to restrictive practices, as they explained:

> Feeling powerless [was the worst part of the restrictive intervention] to be honest with you … You know, when they hold your hands you're not able to do anything you know.[137]

Some people with disability speak about powerlessness in terms of losing all control, as the following person with psychosocial disability expressed in the context of seclusion:

> [I] Felt lost, completely lost, game over.[138]

Notably, as the following person with psychosocial disability subject to seclusion in an acute psychiatric hospital in the United States articulates, experiences of powerlessness in the context of restrictive practices can intersect with experiences of fear and confusion (as previously described in section 2.3 above):

> ... the nurse told me to take my medicines ... the nurse did not explain the situation to me ... rather ... uh ... the nurse called four big guys and they held me ... the nurse refused to listen to me ... uh ... I was ... um ... I was afraid and powerless ... I did not know what they were going to do to me ... I did not have any family at this hospital and uh ... you know ... they outnumbered me ... I was not able to concentrate ... I felt I was going to die ....[139]

Other accounts of powerlessness appear to be linked to experiences of violation (as previously described in Section 2.1 above). For example, as the following person with disability who was physically restrained in an emergency department explained:

> You took all my clothes off, you had me laying on the bed strapped down with no clothes, no cover, no nothing. My privates are wide open, people just walking by, and you won't give me no clothes or shut the curtain.[140]

While some accounts of powerlessness reflect some of the experiences of trauma and counterproductive 'treatment' that were also captured in Section 2.1 above. This dynamic was illustrated in the following account by a person with psychosocial disability subject to seclusion:

> … I was feeling very low, I couldn't have felt any lower I thought, until they put me in seclusion and then I realized you could go lower. But by then there was nothing I could do about it. They even take away your option to change the circumstances to try and lift your mood.[141]

Many of the accounts of powerlessness and restrictive practices we found also described how these experiences amounted to a broader experience of humiliation. Indeed, experiences of humiliation, powerlessness and restrictive practices were voiced across a full age range of people with disability. Thus, for example, in the context of school settings, a parent of a child with disability spoke about their child's experiences of restrictive practices as follows:

> My child was abused at mainstream school. She was humiliated, isolated (and) placed in the corner facing the wall ... That is just the tip of the iceberg of what happened to her.[142]

With another parent similarly expressing:

> (My son) was humiliated in his last school, he was stuck between two flag poles (in) rain, hail or shine and was told by the teacher if he leaves that spot he will be expelled. He was put on parade as a naughty child and when I rang this teacher he told me "what is your problem, I stick my head out the window to make sure he's ok, he's not thirsty or needs to go toilet".'[143]

While the above articulations of humiliation and powerlessness are provided by parents of children and young people with disability, and not the child or young person themselves, we note the following two relevant observations. First, the humiliating experiences of restrictive practices these parents articulate on behalf of their child are reflective of many of the themes we've previously captured through first-hand accounts by people with disability. The emphasis on being left alone, abandoned, for example, was a commonly expressed experience by people with disability that we described in Section 2.2 above. Second, these elements of abandonment and additionally being put on humiliating display for others are reflected in some adults with disability's accounts of their experiences of restrictive practices as powerlessness and humiliation. Indeed, some international studies note that disempowerment in the form of humiliation was a particular concern for women with disability, such as the following account by a woman with psychosocial disability in the context of seclusion:

> It's humiliating, having male staff seeing me naked and you've got to face them. Yeah, there was females there too, but they don't care if there's male staff there watching while you're naked, couldn't care less.[144]

The above account of humiliation bears a striking resemblance to the accounts of violation, harm and trauma previously described in Section 2.1 above. We further note that these experiences of humiliation, powerlessness, violation, harm and trauma often appear to work together, such that some people with disability subject to restrictive practices are dehumanised, stripped of dignity, and unrecognised in their requests for assistance and support. As discussed in Chapter 1, 'ill-treatment' might be understood as a dehumanising form of violence which, even if it does not rise to the threshold of 'torture', nevertheless denies the dignity of those who experience it. As the following person with psychosocial disability explains in the context of a mental health setting in Australia:

> There was an incident where I went to the hospital, let's just say against my better judgment, and against my will for that matter, they decided that I had a weapon on me, where I would have got it I have no idea, so they made me literally strip down to nothing and wait in a room while they searched my clothes which apparently had bomb residue. I have no idea, basically I had to stand there naked and it was a room literally it was just like a standard hospital room... with the doors with the glass windows and people were just walking past. Who cares, he's only a psych patient, who gives a crap. And that's the way it felt. You literally just get de-humanised and it's sort of that once you have become part of that system you do become almost, well not completely, but treated in a sub-human way. You can do things that you would not normally do.

> If you had a cancer patient in that same situation the furore would be terrible with the treatment they receive.[145]

Similar sentiments of being treated in a way that is unreflective of the dignity of a person was expressed by the following person with psychosocial disability, who characterises this treatment as torture:

> All they came to do is bend me over and give me meds and throw food on the floor and leave … If you treat me like a 31 year-old man I would be OK. When you breach human rights, they make you feel worthless. I think supervised confinement is not the answer, people are meant to be cared for, not tortured.[146]

These experience of 'who cares, he's only a psych patient', and being treated in a way that would not be acceptable if it occurred in relation to someone without a disability, was also reflected in the following evidence provided by the daughter of a man with dementia in aged care in the recent Royal Commission into Aged Care Quality and Safety. The daughter recounted:

> As I was walking him out I noticed his pants were wet, and that he was wet. This was the first time I had noticed he was in an incontinence pad. He was toileting himself the last time I had seen him. I told the nurse he is wet through and would need to be changed, and she took him away and she said, 'Okay, we'll sort that out'. So I went and sat outside in the courtyard with my girlfriend and waited. And then another nurse, different from the first two that I had seen that day, called for me from a resident's window, I think, called me and said 'Can you please come inside and see this.' As I quickly jumped up and rushed inside and had to go out of the locked East Wing and into a corridor and into a bathroom, she said, 'Don't be upset by what you see', and by that stage I could hear dad yelling, saying, 'Stop it, stop it'.
>
> I walked in and there would have been about six – six nurses hanging onto him. He had one on each leg, one on – holding both his arms, and this other nurse said to me, 'Maybe if he sees you he will settle down.' And another one was grabbing his pants and pulling them down. They were just all hanging off him. There was a lot of yelling and screaming and dad saw me and... he got an arm free and grabbed hold of my arm and he started saying 'No. No. Stop it.' It was very traumatic for him and for me. They sort of rushed, got it all finished, pulled his pants back up. When I turned around my girlfriend was standing in the doorway of the bathroom, and all the nurses left and dad grabbed my arm and said, 'How would you like it?' and my girlfriend said to him 'No, I wouldn't like it either.' And that was that.[147]

Lastly, we note that while some people with disability and those closest to them used terminology of dehumanisation to describe their experiences or restrictive practices, other first-person accounts simply described experiences which are blatantly inhumane, humiliating, and unacceptable, without the person needing to name the experience as such.

A core example of this includes the following account by a First Nations woman with disability subject to seclusion:

> Well they put me in isolation and I needed to go to the toilet. I'm knocking, knock, knock, knock. [Calling] 'Come on, I need to go toilet. Can someone open up please?' Nothing, nothing, nothing. So, [calling again] 'I need to go the toilet can someone open up please?' I thought oh stuff this ok. Pee my pants. Then I laid down and I was wet laid down and wait till they come in to let me out. Then I had to clean the mess up then I could get back into the ward . . . [I thought] Oh, just smart arseholes, fine I'll clean the mess up kind of attitude.[148]

The above accounts by people with disability and those closest to them begin to give shape to some of the humiliation and dehumanisation that restrictive practices bring for people with disability. These accounts also scratch at the surface of another set of interrelated elements enmeshed in experiences of restrictive practices: the cruelty of restrictive practices, and their punitive nature. We explore this set of elements separately next.

2.5 Cruel and punishing treatment

There were many examples in the material we collected of people with disability or those closest to them describing experiences of restrictive practices as cruel and/or as punishment. As discussed in Chapter 1, ill-treatment under CAT can include 'cruel' forms of violence; that is, violence that is excessive, beyond necessity and demonstrates inhumanity in the person who inflicts it. Punishment need not inherently constitute torture or ill-treatment. However restrictive practices should not operate as a form of extra-judicial punishment. If people with disability experience restrictive practices as punishment for their behaviour, then this indicates a problem. In the experiences collected for this report, we found many examples where restrictive practices was experienced as both cruel and as punishing.

Many parents of children and young people with disability have provided testimony about the cruelty and inhumanity inherent to their child's experience of restrictive practices in school settings. Examples of some of the cruelty that some children with disability are exposed to through their experiences of restrictive practices in school settings include being expected to stay within inhumane conditions, as described in the following parent's account:

> My child would spend most of the time he was permitted to attend school (which was under two hours) in a room with his aide with no windows. I would like to see any adult be subjected to those conditions and see if they cope.[149]

Or, similarly, as another parent of a child with disability expressed:

> My son was made to do his one on one work in a storeroom cupboard, no windows, shelves stocked high with supplies ... how depressing![150]

While other parents have spoken about the cruelty inherent to their child being caged at school:

> (At my son's school there) was a huge cage in the middle of school, the school was padlocked once kids were in and parents were not allowed to be involved in their education. I cried every day I dropped him there.[151]

And other parents have testified about a range of cruel and inhumane treatments that children and young people with disability may be subject to, such as the following account of a parent of a child with disability:

> My son has been sprayed with water to 'stop' a behaviour. He had his face held by an aide to teach him to look him in the eye. He was locked in a room alone with a ceiling fan going for most of the day, when I collected him he was on the floor asleep in his own vomit.[152]

Again, it is always important to acknowledge that each of the above accounts of restrictive practices have been provided by parents of children and young people with disability and not the person with disability themselves. We note, however, that similar experiences of cruelty and inhumane treatment have been voiced by adults with disability. Indeed, the following adult with disability who has been subject to seclusion describes the cruelty of that treatment as follows:

> Angry and animalistic … caged, cold … felt treated like an animal.[153]

Notably, it was not uncommon in the experiential data we collected from past research for people with disability to describe the person who subjected them to restrictive practices as 'angry', much like the person in the above account did. In a study of an independent psychiatric hospital on five wards that provide secure care for people with intellectual and developmental disabilities, many of these people with disability perceived the nursing staff in charge as being angry, or as hating them, or as enjoying the cruel treatment they were inflicting upon them. These sentiments were well captured in the following testimony by a person with intellectual and developmental disability who explained:

> The staff are angry with me, angry with me. Is it meant to hurt is it? I think that people hate me, I do think they hate me. They were laughing about it … those lot in there – the staff in there. They [nursing staff] were happy, I don't know why. They put my hands behind my back. They were really pushing it, really angry about it I reckon some of the staff here might seclude people just to prove they are in charge.[154]

Similarly, in a study of people with disability who were physically restrained in the emergency department, a person with disability recounted how:

> The lady who told me to shut up, one of the nurses, she pushed my face in like that. I say, 'I can't breathe; you're hurting my neck. Let me go. You people are hateful the way you treat me.' After I was tied up, she just gave me the finger. The policeman who was nice to me, he just looked at her like he knows she's doing something wrong, but they don't say anything.[155]

As Ben, a young person in secure care in Sweden describes, sometimes the cruel and punitive treatment of restrictive practices simply feels like 'hell'; as Ben said:

> They use punishments, if you don't listen then you are punished. … Smack, smack, that's it. … it's no help, there is no help in it. … It's hard to explain, you have to be there to understand. You cannot believe there are such places. I thought that this would be okay, I mean, it's care. But I was wrong. … It's not care. It's just hell. They made a hell for me.[156]

Interestingly, while in Ben's case he is speaking about the disjuncture between a person's expectation for 'care' and their experiences of formalised punishments, in several other accounts we collected, a similar disjuncture appears to have formed between a person's expectation for 'care' and the treatment they received from others, which they perceive as punishment. We see this disjuncture, for example, reflected in the account of Indigo Daya in the recent Royal Commission into Victoria's Mental Health System. As Ms Daya explained:

> I remember one time when I attempted suicide while I was an inpatient. I often used to believe that I was a bad person, and that I should protect the world by killing myself. The attempt failed. When the staff found me, I was forcibly walked straight to a seclusion room and locked in by myself. This was a terrifying and deeply shaming experience. There was nothing whatsoever to distract me from the overwhelming emotions, and I concluded that I must indeed be a terrible person, because they were punishing me.
>
> I remember hitting myself in the head, over and over. Looking back, I think this was absolutely cruel and inhuman treatment, and a very serious rights violation. I wish that those staff had instead been able to sit with me in a quiet room, show some compassion and empathy, and just asked me what had led me to feel this way.[157]

Ms Daya is not alone in concluding that she 'must indeed be a terrible person, because they were punishing me'. This rationalisation of the cruel and punitive experiences some people with disability are subject to when subject to restrictive practices was present in several other accounts, including the following account by Sarah, a person with psychosocial disability, who explained:

> it makes me feel like a monster, like I've done something really wrong (.) like I'm gonna get out the building or I'm going to hurt somebody but I couldn't get out this building if I tried and I certainly wouldn't hurt anyone.[158]

Or as Malik articulated in the same ethnographic study of psychiatric ward life:

> I don't understand it I mean if you're a criminal and such things then I'd understand it a bit more but we're not we're not supposed to be criminals here know what I mean most of the people here have never been in prison so I don't know why we're treated like prisoners.[159]

Or as the following person with psychosocial disability explained in an Australian study of seclusion and restraint:

> Deny people their freedom, for example if it's restraint of freedom of movement, or the freedom to ask questions, the freedom to be able to interact with other people, I mean isolation basically is almost another form of punishment, you've been bad, you've done something wrong. I mean that's how I see somebody being isolated. And takes that confidence away, because you must be bad so you are in isolation.[160]

Notably, it was common for us to find examples of people with disability making analogies between their experiences of restrictive practices and experiences of prison. For instance, in a study of individuals who were physically restrained in the emergency department, a person with disability stated:

> I felt like nobody really cared. I felt like I was in prison, in the bed. I've never been to jail before, so my first experience of it was scary for me. I'd never been restrained before, I never had anyone hold me from my rights, you know? I cried, you know, I felt like I was alone in the bed with the straps on my wrists, my ankles.[161]

Although, as the following person with psychosocial disability made clear in the recent Royal Commission into Victoria's Mental Health System, the experience of restrictive practice can also be 'worse than prison' too:

> Seclusion is worse than a prison – you are given a petri dish to urinate and cups of water to stay hydrated. You are in a very enclosed environment. Extremely demoralising and embarrassing. Seclusion is creating more detriment to a person's recovery ... I was put in there because I attempted suicide but I shouldn't be punished for that.[162]

And, as the following case study of James, which was compiled by the Australian Cross Disability Alliance for their 'personal stories and testimonies' submission to the Senate Community Affairs References Committee *Inquiry into Violence Abuse and Neglect Against People with Disability in Institutional and Residential Settings* attests, sometimes people with disability may feel like they would rather be in prison than endure the 'care' provided through use of restrictive practices:

> James is 24 and has acquired brain injury. He has been ordered to live in a 'community forensic facility' after being found unfit to plead to a charge of assault. The 'duplex' where he lives is on the same grounds as the prison and he lives there alone, his only regular contact being with the staff who monitor the 24 hour surveillance from the observation window.
>
> A cage covers the small outside yard and windows and doors are locked, including the bathroom so he must request permission to use the toilet, shower or to get water. The duplex contains one table and bench bolted to the floor and a bed. James has no visitors

> as his parents live hours away, he has little opportunity to exercise and there are no recreational opportunities – he has no books, TV, radio or computer to maintain contact with the outside world. He told his independent advocate, "I don't understand why I'm here, I'd rather be in prison".[163]

2.6 Lifelong trauma and life-altering effects

In the above five sections of this chapter, we have shared numerous examples of people with disability and those closest to them voicing the violence, pain, suffering, harm, humiliation, cruelty and dehumanising effects of restrictive practices. In this final section of the chapter, we seek to broaden our understanding of people with disability's experiences of restrictive practices by drawing attention to the lifelong and life-altering effects of being subject to this form of violence. As discussed above and in Chapter 1, torture under international law refers to a severe form of physical or mental suffering. Experiences of lifelong physical or mental trauma assist to identify the severity of violence associated with forms of restrictive practices.[164]

In seeking to bring forth some of the lifelong and life-altering effects of restrictive practices in this chapter, we note that in the data we collected from past research, it was, once again, often the parents of children and young people with disability who were well placed to observe changes over time in their child. Typically, parents of children with disability saw the lifelong and life-altering effects of restrictive practices as stemming from the trauma of these practices. Parents spoke of the ways that their child had been traumatised by their experiences of restrictive practices, and how their child now experiences ongoing fear and anxiety as part of their broader life. As the following parent of a young boy with disability explains:

> At the school that my son used to attend, he and two other children aged five to six years old were locked inside a small windowless room called the 'thinking room.' My son now has a fear of small confined spaces such as lifts ... I was not informed before or afterwards by his teacher or school Principal of this event. It is only years later that my son remembers and has had the courage to tell me.[165]

Similar accounts of the ongoing traumatising effects of restrictive practices were voiced in the following descriptions of Joan and Frank's experiences. These accounts of Joan and Frank's experiences were provided in a submission of personal stories and testimonies that were collected by the Australian Cross Disability Alliance and submitted to the Senate Community Affairs References Committee *Inquiry into Violence Abuse and Neglect Against People with Disability in Institutional and Residential Settings.* In that submission, it was detailed that:

> Joan has Autism and was restrained by staff at her school at one stage for up to 45 minutes every morning. Her parents withdrew her, and the next school also restrained her. She is now so traumatised she cannot attend any school. She is only nine years old and the State Government Education Department has made little effort to assist her with the psychological treatment she needs to recover from the abuse.[166]

The submission further detailed that:

> Frank has multiple impairments including Autism Spectrum Disorder. Frank told his mother he was taped to a chair while at school, and this was confirmed by the tape marks on his wrists. He was locked in rooms and subjected to restraint on numerous occasions, at least once witnessed by his mother. When attempting to make a complaint some years later, the school refused to admit the abuse occurred, and said they had no documentation so could not investigate the complaint. Frank was a young primary school child, and still suffers the trauma of those years. No assistance has ever been offered by the State Government Education Department at any time and Frank ended up being hospitalised halfway through his primary school years due to psychological damage.[167]

We note that each of the above three accounts of the lasting trauma of restrictive practices are consistent with many of the other accounts of restrictive practices voiced by parents in this chapter. At the same time, each of the above three accounts also hint at some of the institutional secrecy, obfuscation and closed operations that may surround use of restrictive practices in some settings. We will return to consider issues of secrecy, obscurity and closed operations when we describe and explore the broader ecological system surrounding the use of restrictive practices in the next chapter (Chapter 3), as well as when we consider what is known about the core drivers for restrictive practices in Chapter 4. For now, however, we draw attention to what has also been common to each of the above three accounts: articulation of the ongoing psychological damage that can be associated with a person being subject to restrictive practices. Indeed, what these three accounts offer us is partial insight into the ways that the damage of being subject to restrictive practices can extend beyond the immediate moment or moments when violence, harm, pain and suffering are being perpetrated and experienced, and into the future of the person with disability.

Importantly, while each of the above accounts relate to school-aged children and young people with disability, the ongoing, traumatising effects of restrictive practices are not unique to this group. Many adults with psychosocial disability who are subject to restrictive practices in mental health settings also voice these effects. Indeed, elements of the ongoing trauma associated with restrictive practices was aptly captured in two accounts by people with psychosocial disability in the 2014 *Seclusion and Restrain Project Report* that was prepared for the National Mental Health Commission by the Melbourne Social Equity Institute. In the first account, presented below, the person with psychosocial disability speaks to the ways that the damage of being subject to restrictive practices extends beyond the immediate moment or moments when violence, harm, pain and suffering are being perpetrated and experienced; as they explain:

> So what I've seen with people who've felt, when they've had even a single 24 hour experience of seclusion and restraint under the mental health system, which is the door, the police, the medication, down into the whatever, the taking of the clothes, the whole lot – that person's changed forever in their feeling and their relationship to the society around them. To every other state agency they're changed, and that allows, that's again that learned helplessness.[168]

These sentiments of a person being 'changed forever' because they have experienced restrictive practices, even if only once, was again reiterated in the second account from that report into seclusion and restraint. As the following person with psychosocial disability explained:

> But the other thing I wanted to raise while I was just thinking about, just seclusion and restraint, the very practices themselves, are sort of very anti- recovery ... [Recovery is] all about self-responsibility, self-direction, and then seclusion and restraint is all about someone else's control, so it doesn't actually sit with recovery at all. And apart from the human rights abuses of it and the trauma that you carry for the rest of your life, when you're actually already at a point when you're severely traumatised when you go to a hospital and then you get extra trauma from it, it doesn't sit at all with recovery.[169]

Once again, we note that each of these accounts of the traumatic effects of restrictive practices are reflective of many of the other accounts of restrictive practices presented in this chapter. In particular, the above two accounts echo many of the experiences of disempowerment, humiliation and dehumanisation outlined in Section 2.4 above. At the same time, the above two accounts additionally hint at other issues and dynamics surrounding restrictive practices. We see, for instance, the potential for restrictive practices to work against the objectives and responsibilities of different institutions to provide services and supports for people with disability. We return to further explore in greater detail these issues and dynamics of counterproductive practices when we consider the broader ecological system surrounding use of restrictive practices in the next chapter (Chapter 3), as well as when we consider what is known about the core drivers for restrictive practices in Chapter 4. For now, however, our purpose is simply to return attention to the critical point that the above two accounts of traumatisation have made clear: being subject to restrictive practices, even if only once, can mean that a person is 'changed forever'.

Of course, it is also necessary for us to acknowledge that the accounts of traumatisation, of being changed forever, of ongoing psychological damage that we have provided above have all come from people with disability (or those closest to them) who are somewhat 'enabled' to give voice to these experiences. By this we mean, these are accounts provided by people who are not subject to restraint or seclusion at the time, nor are they accounts provided by people residing within a closed institution. On the latter point, it is difficult to find any first-person accounts of the lifelong and life-altering impact of restrictive practices from people with disability who are subject to closed institutions such as group homes, aged care facilities and forensic facilities. We were, however, able to locate three illuminating accounts from people who support people with disability in these settings.

The first account, provided by the Australian Cross Disability Alliance in their 2015 submission of personal stories and testimonies to the Senate Community Affairs References Committee's *Inquiry into Violence Abuse and Neglect Against People with Disability in Institutional and Residential Settings*, concerns 'Luke'. The account reads as follows:

> Luke is 21 and has autistic spectrum disorder. He lives in a residential facility. Before going into care Luke was well groomed and spoke quite well. Since entering the facility Luke's condition has deteriorated to the point of self-harm, after spending hours each day locked in a room with little more than a bed and a toilet. He is severely depressed, refuses to wear clothes and often will tear them to shreds. He is completely alone, even his food is passed through a door.[170]

A similar story of deterioration over time was shared in the following case study of 'Adam' provided by Queensland Advocacy for Inclusion in their 2021 submission to the *Legal Affairs and Safety Committee on the Inspector of Detention Services Bill 2021*:

> Adam resides in a high secure mental health facility under a forensic order. He is considered high risk of reoffending and suffers from a dual disability, a complex treatment resistant type mental illness and an intellectual impairment. Adam has resided in the high security unit which is a seclusion type arrangement for over 6 years. Adam has very limited access to leave and is currently only permitted by order of the Mental Health Review Tribunal to access escorted on ground leave on the campus of the high security mental health unit which he to date, has not been successful in accessing for some years.
>
> Other than his confinement, Adam is supported to access leave to the common room on the ward where he has access to books. He is only able to access the common room in isolation due to the threat he poses to co-patients. He regularly declines opportunities to leave his room as he considers that his belongings in his room will be stolen or taken if he leaves, which is part of his condition. Any contact with family, or his lawyers is at a distance due to the risk of harm he poses to others and is usually facilitated via contact through a secure fence on the perimeter of his seclusion room or by a phone being placed on speaker through the hatch door in his room. This poses serious concerns for his rights to privacy, connection with family and access to his lawyer.
>
> Adam's family have observed a longitudinal regression in his condition and perception of self. The clinical treating team have also noted that Adam regularly declines opportunities to leave his room or participate in recreational activities and exercise opportunities on the grounds of the hospital, such as swimming which he reportedly enjoyed many years ago.
>
> Adam identifies that he is a dangerous person and should be in jail and regularly makes verbal threats to harm others.[171]

Both Luke and Adam's stories echo some of the earlier accounts presented in sections 2.4 of this chapter about people with disability coming to the belief that there must be something wrong with them if this is how they are treated. Luke and Adam's stories also provide further insight into the ways that restrictive practices may in fact be worse than prison for some people with disability, a sentiment previously explored in section 2.5.

In the case of Luke and Adam's stories, it is difficult to overlook the similarity of their circumstances. Both spend the vast majority of their time alone. Both are restricted in their freedom to move around and participate. Both accounts describe the interaction between institutions, segregation and an experience of progressive deterioration and loss of self. While we return to this last point when we consider the broader ecological system surrounding the use of restrictive practices (Chapter 3) as well as the core drivers for restrictive practices (Chapter 4), for now we note that these are not the only factors that appear to contribute to deterioration of people with disability over time. Indeed, in the final example we were able to find of restrictive practices in closed settings leading to long term deterioration, the restrictive practice in use was chemical restraint:

> For the first week mum was in the high care ward she was heavily sedated – I mean couldn't talk and couldn't keep her eyes open or head up! which was a shock as just the day before she was having very normal conversations and meeting with her friends out in the general area. When I questioned staff, they said she was unsettled so they gave her some drops on her tongue to keep her calm. Of course you believe them as they are the professionals with training to look after our elderly...Mum never recovered back to where she was the day before she went into the high care area, she couldn't walk unassisted, she couldn't talk or communicate in any way, couldn't eat.[172]

This story of a mother in a high care ward reminds us again of how important it is to recognise that it can be a single experience of restrictive practices that can traumatise someone just as much as it can be the repeated use of restrictive practices over time that contributes to dehumanisation and a breaking down of the person. This story also begins to indicate how for some people with disability, the trauma of restrictive practices contributes to a deterioration of self. The story suggests that restrictive practices are not just capable of fundamentally changing the life of a person with disability, but also fundamentally changing how that person understands themselves and locates their meaning in their life. On this last point, we can see some of the strongest examples of these changes in self and meaning when reading the accounts of women with disability who have been subject to forced sterilisation. We present these accounts below.

For many women with disability who are provided with the opportunity to speak about their ongoing experiences from being forcibly sterilised, the core impact that consistently comes forward is the loss of their ability to have children and the consequence this holds for how these women understand themselves as women. This dimension of life-altering and life-shaping loss is evident in the following first-person accounts of women with disability who have been forcibly sterilised:

> It stops us from having children if we want to.[173]

> Sterilisation takes away your womanhood.[174]

> I do want to have children but I can't now.[175]

> For me it has meant a denial of my womanhood.[176]

> I was what I call, 'socially sterilised' – I had the operation when I was a young woman because growing up I had been brainwashed to believe that disabled women like me can't be mothers. I would have loved to be a mother. There are of course, no proper words to describe the loss, the guilt, the regret and the pain I feel every day.[177]

But it is important to understand that forced sterilisation, and the resulting inability to have children, is not the only factor that can impact on a woman with disability's sense of womanhood. Rather, as the following accounts by women with disability detail, forced sterilisation can also impact on a woman's sexual identity:

> It has resulted in loss of my identity as a woman, as a sexual being.[178]

> I have a fear of not being seen as a sexual identity – of sexual rejection.[179]

> If they'd told the truth and asked me, I would have shouted 'No!' My sterilisation makes me feel I'm less of a woman when I have sex because I'm not normal down there..... When I see other mums holding their babies, I look away and cry because I won't ever know that happiness.[180]

As the last account above suggests, it is important to clarify here that for these women with disability, the impacts of forced sterilisation are numerous. It is not just that it stops these women from having children, or that it stops these women from developing a full sexual identity. It is that forced sterilisation has both these impacts, as well as others, such as significant long-term health implications as outlined in the next few accounts by women with disability:

> Because I have had important parts of my body taken away it is hard to find out what is really going on in my body.[181]

> I am ... taking a big risk on behalf of myself and my family in speaking up. I would like to know what is being done for us who have had this done twenty or thirty years ago? I don't have an intellectual disability and it was done before I started having a period. What research is being done to help us who were young children that went through this, and when we go through menopause? It can affect our health in the future. I think of this as my real disability – the physical one that you see isn't real – the one I had happen to me when I was 12 is the main one and I don't have anyone to turn to.[182]

> I worry about the future health effects like osteoporosis and other problems.[183]

Finally, what forced sterilisation also does for some women with disability is add another dimension of being set apart from other people without disability, as painfully captured in the following three accounts by women with disability:

> Other women don't understand what its like for us – it sets us apart from them.[184]
>
> I feel alone and isolated.[185]
>
> I have been denied the same joys and aspirations as other women.[186]

As discussed in Chapter 1, restrictive practices are at odds with obligations to equal treatment and non-discrimination. Under Article 5 CRPD, States Parties have an obligation to 'prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.' Restrictive practices, where they are applied on a discriminatory basis against people with disability, are at odds with this prohibition on discrimination. Further, the UN CRPD Committee have made clear the obligation to prohibit 'all forms of forced sterilization' and in its 2019 Concluding Observations called on Australia to 'review and amend laws … in line with the Convention and adopt uniform legislation prohibiting, in the absence of free and informed consent, the sterilization of adults and children.'[187] The accounts above on forced sterilisation highlight in stark terms the material effect of this legal form of discrimination, which denies opportunities for people with disability to have the same reproductive rights and rights to bodily integrity as other members of the community.

As well as shaping people's self-identity and life trajectory, restrictive practices can also compound past traumatic experiences and need to be understood in the context of individual and social history. This is particularly so for people who have had previous experiences of institutionalisation, forced treatment, and restraint. This is explained by the National LGBTI Health Alliance in relation to LGBTI people in aged care:

> Care needs to be taken with related consequences of restraint because of historical and contemporary practices of attempted psychiatric 'treatment' of LGBTI people, such as aversion therapy, which is still legal and used in some parts of Australia.
>
> "I grew up in an institution so I associate places like residential aged care with mistreatment. What happened in those institutions was not good for the kids. I got lots of beltings. I don't like to be mistreated." -seventy-eight-year-old urban transgender woman.
>
> The majority of aged care services are provided by faith-based organisations. Some faith-based organisations continue to advocate for the efficacy of conversion therapy despite there being no evidence that it is successful in changing a person's sexual orientation or gender identity. Older LGBTI people understand that conversion therapy practices are ineffectual and harmful and feel vulnerable to any kind of physical intervention related to their behaviour. LGBTI older people with a lived experience of electro-convulsive shock therapy can experience added trauma if chemical restraint is used. […]
>
> "Some workers have beliefs from their faith and their culture which are backed up by management. They believe that being LGBTI is sinful." – fifty-year old urban bisexual woman, carer for a disabled younger person in residential aged care.

> Older LGBTI people describe many different scenarios where restraint could trigger previous trauma or disrupt current healthcare regimes. For a person in recovery from substance use, chemical restraint could be breaking their sobriety. And for people living with HIV, or trans and intersex older people, chemical restraint may interfere with their medication. If these complex issues are discussed with the individual or their loved ones before the use of chemical restraint, further health problems can be avoided.[188]

2.7 Conclusion

This chapter described some of the core, common experiences of people with disability who have been subject to restrictive practices. The chapter drew its data from scholarly literature, reports, government inquiries, and the submissions that have been made to those inquiries. Section 2.1 explored articulations of trauma – that is pain, harm and violation – that some people with disability voice when reflecting on their experiences of being subject to restrictive practices. Section 2.2. explored stories of neglect and abandonment that have been voiced by people with disability and those closest to them. Section 2.3 attended to experiences of fear that often surround and intersect with the experiences described in sections 2.1 and 2.2 of this chapter. Section 2.4 presented accounts of dehumanisation and degradation that people with disability and those close to them have shared when reflecting on the impacts of restrictive practices. In section 2.5 we explored some of the descriptions people with disability have provided of experiencing restrictive practices as cruel, and as something akin to, but at times also 'worse' than, punishments inflicted in the criminal justice system. Lastly, in section 2.6 we described some of the long-term trauma and life-altering effects that restrictive practices have on people with disability.

Together, the six sections of the chapter give voice to the ways that use of restrictive practices described above strip people with disability of dignity. As Chapter 1 of this report detailed, threaded through many core human rights, and reflected in obligations to protect people with disability from torture and ill-treatment, as well as any form of discriminatory treatment, is the concept of 'dignity'. Restrictive practices strip people with disability by failing to meet these obligations, with people with disability experiencing restrictive practices as violent, harmful, traumatising, cruel, disempowering, dehumanising, punitive, and degrading treatment that invokes fear and terror.

As outlined in the introduction to this chapter, our goal in the chapter, as well as in the report as a whole, is to centre the experiences of people with disability. We value the expertise, and respect the loss and pain that lies within the experiences described in this chapter. We see these experiences as the foundation for an understanding of restrictive practices. Before we finish the chapter, however, it is important to momentarily broaden our remit. We say this because, the impacts of restrictive practices do not solely lie with people with disability. Rather, there are many people without disability who are effectively being taught lasting lessons about current expectations surrounding how people with disability deserve to be treated when they watch a person with disability being subject to restrictive practices. In this respect, as we

discussed in Chapter 1, restrictive practices deny dignity in two different ways. First, they refuse to recognise the inherent dignity of the person who experiences them. Second, in inflicting this violence, restrictive practices act as a 'civic marker' by treating people with disability in ways which remove their dignity and devalues their status. In this respect, restrictive practices potentially participate in the society wide discrimination and stigma experienced by people with disability, and as such have impact for both the recipient and society in general. As the following accounts from parents of children with disability explain:

> My child has witnessed another child being kept in a restraint thereby appearing to normalise this behaviour. Whether you're in the restraint or looking at someone else who is restrained, (it) has an impact.[189]

Indeed, as the following account of what a parent stated in a submission by The Growing Space to the *Select Committee of the Legislative Council's inquiry into Access to the South Australian Education System for Students with a Disability* indicates, when people without disability look at someone with disability who is restrained or secluded, certain problematic attitudes and beliefs can get fixed in place, as the submission detailed:

> One parent verbally stated that other students referred to the segregated fenced yard at their daughter's school as the "retard cage".[190]

We return in Chapter 6 of this report to further consider the significance of restrictive practices having potential impact for both the recipient and society in general. For now, we note that these statements are important because they remind us to consider the broader ecological system within which restrictive practices take place. In the next chapter we once again draw on the voices, experiences and expertise of people with disability and those closest to them to describe some of the core facets of this broader ecological system.

Chapter 3: The ecological system of restrictive practices

In Chapter two we examined the experiences of people with disability themselves who were subject to restrictive practices. As discussed in that Chapter, the research we surveyed highlighted the ways in which people with disability experienced restrictive practices as violent, harmful, traumatising, cruel, disempowering, dehumanising, punitive, and degrading treatment: that is, as forms of coercive and non-consensual treatment that stripped dignity. However, restrictive practices occur within environments where there are many factors at play. As the accounts presented in Chapter 2 indicate, there can be large scale social forces such as racial and gender oppression which intersect with use of restrictive practices. There can also be day-to-day realities such as accommodation settings and staff rosters, which also play a role in restrictive practices use. To this end, these environmental factors which shape and drive the use of restrictive practices might be understood as comprising an 'ecological system.'

In this chapter we consider the broader ecological system within which restrictive practices take shape and are perpetuated against people with disability. In so doing, we lay the groundwork for addressing the first research questions set by the Disability Royal Commission for this project: what are the systemic drivers of the use of restrictive practices against people with disability? How do these differ across settings across Australia?

In using the term 'ecological system' here, we are informed by the 'ecological approach' to violence prevention that has been generated in recent years, and which is modelled on the work of Urie Bronfenbrenner.[191] An ecological approach to violence prevention means, at least in part, to pay attention to the interactions that surround and involve the individual who is subject to violence. As represented in Figure 3 below, typically, an ecological approach involves tracing and exploring the concentric circles of relationships, institutions and social structures that envelop and extend out from that individual, and which enable violence to occur. While traditionally such ecological approaches have their origins in the context of violence against people *without* disability, some scholars have successfully adapted this approach to violence prevention models relating to people with disability.[192]

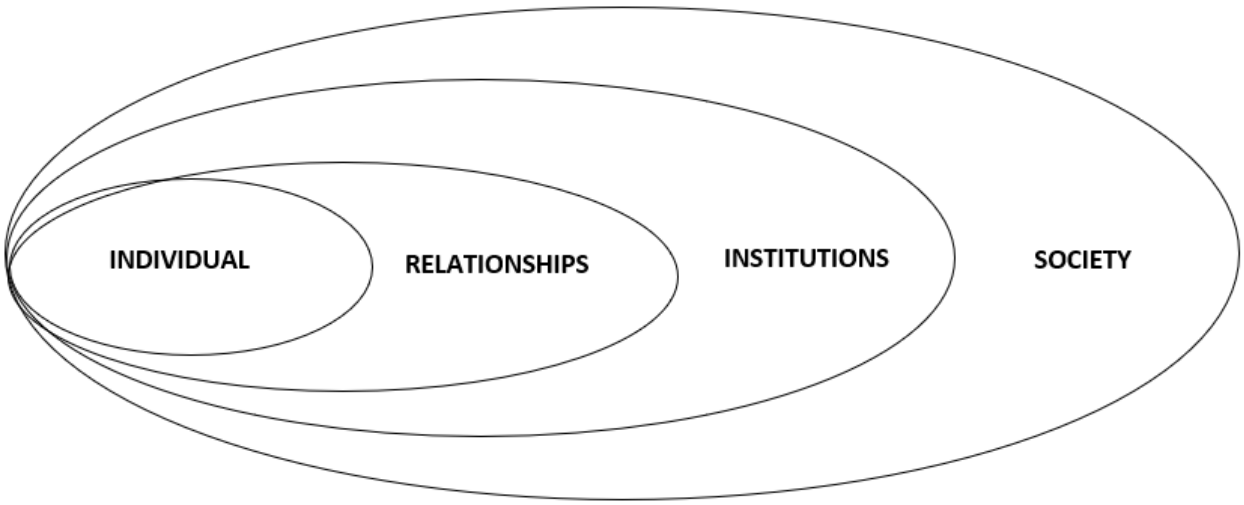


Figure 3: Concentric circles of an ecological approach to violence

In the context of this chapter, we explore the ecological system of violence against people with disability with a specific focus on restrictive practices. We illuminate core elements of this ecological system by continuing the approach we established in Chapter Two: listening to the voices and experiences of people with disability who are, or who have been, subject to these violent, traumatic practices. This means this chapter is based in the expertise of people with disability's lived experience, enabling the voices of people with disability who have been subject to restrictive practices to speak for themselves.

The chapter comprises four main parts. We begin in section 3.1, with the 'individual' circle of the ecological approach. Here we explore the connections between restrictive practices, the unmet needs of people with disability, and what are perceived by some to be individualised 'behaviours of concern'. In section 3.2 we broaden our gaze to consider the relationships between people with disability and those who are empowered to use restrictive practices against them in a range of contexts and settings. Here we pay attention to the ways that restrictive practices break down relationships of trust, and further entrench already unequal power relationships between people with disability and those empowered to use them. In section 3.3 we shift our attention further outward, this time considering institutions. Here we listen to the ways that people with disability articulate their experiences of restrictive practices in relation to institutional cultures of control; cultures where the convenience and priorities of the workplace appear to guide and inform staff use of restrictive practices; and cultures of silence and secrecy. Lastly, in section 3.4 we consider the broader 'societal' elements at play within the ecological system of restrictive practices. Here we pay attention to the encompassing socio-legal norms, attitudes and expectations that enable people with disability to be legally permitted to be subject to the violence of restrictive practices.

3.1 Restrictive practices and perceived 'behaviours of concern'

We begin our exploration of the ecological system of restrictive practices by attending to what is often perceived and characterised in disability service provision and policy as an 'individual' dynamic in the context of restrictive practices: 'behaviours of concern'. Before turning to the voices and experiences of people with disability to explore this dynamic, it is necessary to briefly outline a key tension that surrounds the concept of 'behaviours of concern', and the way this concept is presented in disability service provision and policy. Here we note that 'behaviours of concern' represent the most common justification and rationale for ongoing use of restrictive practices against people with disability at this time. Indeed, while there have been legislative and policy changes made in recent years in an attempt to shift restrictive practices away from being used as a 'first response', and towards being used as a 'last resort', restrictive practices remain available as an option within Australian law and policy at least in part because of their perceived capacity to respond to 'behaviours of concern'.[193] In this context, 'behaviours of concern' are typically presented within Australian law and policy as those behaviours that place the person with disability or others at risk of harm,[194] with these behaviours conventionally understood as resulting from 'the interactions between the person and their environment'.[195]

Over the past decade, the scholarly community has investigated the significance of the interaction between people with disability and their environment in relation to restrictive practices. These investigations have produced three primary explanations relating to the development of perceived 'behaviours of concern'. While each of the three explanations draws attention to a different dynamic relating to the development of perceived 'behaviours of concern', they should not be considered as mutually exclusive. Rather, when viewed together, these explanations provide a more comprehensive understanding of the development of perceived 'behaviours of concern'. In so doing, these explanations raise questions about the apparent necessity to respond to perceived 'behaviours of concern' through use of restrictive practices – a point we explore further in all sections of this chapter, as well as sections 4.2.1, 4.4.2, 5.2.3.2 and 5.2.3.5.

The first element emphasised by scholars is the need to recognise 'behaviours of concern' as *both* a product of the interactions between the person and their environment, *and* as socially constructed.[196] It has been proposed that 'behaviours of concern' is a culturally, and potentially, setting-specific 'socially constructed, dynamic concept', which reflects dominant social attitudes towards people with disability, and which requires someone else to consider the behaviour of a person with disability, and to interpret it as 'dangerous, frightening, distressing or annoying'.[197] To this end, Nunkoosing and Haydon-Laurelut's analysis of group home staff referrals to the UK Community Learning Disability Team indicated that people with intellectual disability and group home staff 'negotiat[e] webs of power'.[198] Specifically, the study found that people with intellectual disability engage in acts of resistance in relation to their restrictive environments. These acts of resistance are reconstructed by staff as 'behaviours of concern', and subsequently used to legitimatise staff use of restrictive practices and referral of these people with intellectual disability

to other health professionals. For these reasons, some scholars, such as Leanne Dowse, suggest that 'behaviours of concern' should be understood as historically contingent, embodied and as:

> relationally produced and constructed – that is – as residing not solely in the individual and not solely in the environment and those others within it – but emerges and is responded to and sustained or otherwise in the interrelationship between person, responder and environment in the context of histories of vulnerability and dependency.[199]

A second, growing body of literature additionally identifies 'behaviours of concern' as serving a communication purpose for people with disability. As Bradley and Korossy state in their 2016 study, behaviours of concern 'can best be considered as communications of distress by individuals unable to communicate their distress in more conventional ways'.[200] In line with this 'communicating distress' understanding of 'behaviours of concern', research has shown that 'restrictive practices may form part of a 'vicious cycle' in which the psychological instability and distress they generate leads to more risk behaviors that in turn result in further restrictive practices'.[201]

Third, some scholars, such as Paul Ramcharan and colleagues further note that '[…] the assumptions of present policy and practice favour a focus on behavioural acts which privilege one form of input, that the input is predisposed to changing the individual and that this necessarily works on pathologising frameworks'.[202] These scholars clarify that '[...] behaviours of concern may equally define the service, rather than being pathologically and unidirectionally attributed to people with disabilities',[203] and that '[a] behaviour of concern is likely to be produced by 'an environment of concern'.[204] Ultimately, these scholars propose that '[m]any behaviours seen as being 'of concern' can be understood better as adaptive behaviours to maladaptive environments; these behaviours can be seen as forms of 'resistance' or 'protest'.[205] They continue that '[b]ehaviours of 'resistance' and 'protest' should be seen as legitimate responses to difficult environments and situations, and not a reason for restrictions designed to change the person and their behaviour.'[206]

In our exploration of the experiential data we collected from inquiries, reports and research, we found many accounts of people with disability and those closest to them speaking about 'behaviours of concern', 'escalating behaviours', 'behavioural problems' and 'behaviour management'. As will be illuminated and considered further below, each of these accounts appear to support the above explanations for 'behaviours of concern'. That is to say, what is articulated about perceived 'behaviours of concern' in the accounts of people with disability subject to restrictive practices we collected, are behaviours that are best understood as both 'adaptive behaviours to maladaptive environments',[207] and as communications of distress, protest and resistance in a historical context of vulnerability and dependency where others (i.e. service providers, teachers) have been empowered to interpret the behaviours of people with disability as 'dangerous, frightening, distressing or annoying'.[208]

As was the case in Chapter 2 of this report, many of the insights we can gain into the connections between maladaptive environments, expressions and perceptions of 'behaviours of concerns', and use of restrictive practices come from parents of children and young people with disability, and not the children and young people themselves. Indeed, the voices of parents of children and young people with disability were cited more frequently in the material we collected than the voices of any other people with disability. There are several potential reasons why this discrepancy has occurred. One potential reason is the cost and time associated with ethically conducting research with children and young people to uncover first-hand experiences of violence, as well as with adult victim-survivors more generally.[209]

While the voices of parents of children and young people with disability cannot substitute for the voices of those who experience violence, parents' accounts can paint a broader picture of some of the connections between factors and changes in their child's life that can often only be observed over time, and from the outside. With this latter point in mind, we note that one of the clearest and most consistent themes to emerge when listening to the accounts of parents of children and young people with disability reflecting on their child's apparent 'behavioural issues', was that perceived 'behaviours of concern' are often 'triggered' by environments that are characterised by restraint, coercion and seclusion (i.e., maladaptive 'environments of concern'). Indeed, as the following parent explains in the context of their son, in their view, the only reason their son had any 'behavioural issues' was because of the environment they had been subject to, as they explained:

> In the disability unit he was left in a room on his own and when he became agitated and broke a window they rang me and suspended him on two occasions. If I left him there any longer he would have been expelled. He only ever had behavioural issues in that environment.[210]

Similarly, as another parent explained about their son:

> The principal carried my son to the sensory room and locked the door. My son had a major meltdown and started to destroy the room.[211]

Concerningly, as the following account by another parent details, despite being aware of the connection between use of restrictive practices and expressions of resistance and protest that are deemed 'challenging' and 'concerning', some educational settings continue to use restrictive practices to respond to perceived 'behaviours of concern'. As the following parent explained:

> My son has been physically restrained on a number of occasions, the school is aware this is a trigger for him, they know it escalates his behaviour but still continue to do it.[212]

This lack of recognition of the connection between the actions of the institution and the resulting responses of the person with disability were also captured in the following accounts by a further two parents of children with disability. As the first parent described:

> My son was locked in a broom closet at high school ... and we were asked to pay for the window that he broke ... (and) the school did not think that it was wrong. I pulled him out very quickly![213]

Similarly, as the second parent explained:

> Recently I have withdrawn my child from school after an incident where six teachers chased him after he walked out of the classroom. One of those teachers had backed him into a corner and (my son) had thrown a book at them and the teacher was incensed because he had done this.[214]

We find it important to note that in three of the four examples provided above, there are references made to the need to withdraw a child with disability from the school they are enrolled in because of use of restrictive practices and the traumatic consequences of these practices. We find this dynamic between restrictive environments, perceived 'behaviours of concern', and the unenrolment of children with disability from schools important for two reasons. First, this dynamic begins to hint at the cyclical nature of the problem at hand. By this we mean, these parents' accounts are suggestive of the ways that a cycle of increasingly tightening restraint and coercion can take form. These parents' accounts describe how children with disability are subject to maladaptive environments of concern to which they respond to through resistance and protest, with this resistance and protest in turn responded to by both more restrictive practices and more options and more choices removed from the child. At the same time, and second, the accounts by these parents also offer insight into the cyclical connection between unsupportive and maladaptive environments and perceived behavioural outcomes. That is to say, the reason these parents are unenrolling their children is because these children's schools are not meeting the rights and needs of these children, And yet, through their unenrolment, many of the needs of these children will remain unmet. We return in sections 3.1.2 and 3.1.3 below to further consider these complex and cyclical connections between unmet rights and needs, perceived 'behaviours of concern', and restrictive practices. For now, we return to one of the core insights raised in these parents' accounts of their children's experiences: the 'triggering' effects of restrictive and coercive environments.

Parents of children with disability were not alone in observing the 'triggering' effects of restrictive and coercive environments. In the experiential data we reviewed, this 'triggering' effect was identified by a range of different people with disability, and described as occurring in a range of different institutional settings. In the context of mental health institutions, for example, the following person with psychosocial disability, Malik, questioned whether restrictive practices resolve, or instead exacerbate perceived aggressive behaviour in psychiatric wards. Malik explained:

> yeah if some of them are quite aggressive some people here are quite aggressive so (.) maybe they need to be restricted but if they weren't restricted in the first place I wonder if they were going to be that aggressive in the final instance kind of thing.[215]

While Malik's account focused on the ways that restriction can precipitate 'aggressive' behaviour on the ward, Sarah, another person with psychosocial disability, focused on the ways that restrictive practices such as seclusion in a locked ward can precipitate self-harm. As Sarah explained:

> Sarah (SU 7): You do four hours in there and if you still don't calm you down they can put you in for another four hours, because I stayed in there for eight hours because I didn't calm down. I banged my head and had a big lump out here, kept banging and banging.
>
> Researcher: Why were you banging your head?
>
> Sarah (SU 7): Stressed. I always do it, go in seclusion [pause] I just smash my head. I had a piece of string in my pocket, they got my pocket and they didn't get everything out and I got the string and cut myself in seclusion.[216]

In the 'Personal Stories and Testimonies' submission by the Australian Cross Disability Alliance to the *Senate Inquiry into Violence Abuse and Neglect Against People with Disability in Institutional and Residential settings* (hereafter, *Senate Inquiry*), the Australian Cross Disability Alliance provided the following, similar, case example of Dave, a young Aboriginal man who is residing in a forensic facility:

> Dave is a young Aboriginal man with intellectual disability. He was found 'unfit to plead' in a criminal matter. He was indefinitely detained in a maximum security prison. Dave does not have access to the intensive rehabilitation programs he needs to address the causes of his offending behaviour.
>
> He is often isolated in his cell for approximately 16 hours a day, and frequently shackled during periods he is outside his cell. In response to repeated banging of his head causing bleeding, prison officers strap him to a chair and inject him with tranquilizers until he is unconscious. This has happened on numerous occasions.[217]

Dave's case offers insight into the role that the broader restrictive environment can play in the generation of acts of resistance and protest that are perceived as 'behaviours of concern'. That is to say, while Malik and Sarah's accounts both speak to the ways that specific uses of restrictive practices precipitate 'behaviours of concern', Dave's case further illuminates the broader restrictive environment in which Dave is situated. Dave's case illuminates how this broader restrictive environment precipitates Dave's self-harm, which is in turn responded to with further restrictive practices.

Crucially, it would be easy to assume that Dave's experiences of increasing restraint are purely circumstantial – that is, that Dave's original experiences of restraint only take shape because Dave is located in a maximum-security prison, which is required to be a highly restrictive environment. However, a similar dynamic was captured in research by Paul Ramcharan and

colleagues into restrictive practices in group home settings. In theory group home settings should not be highly restrictive environments. In this piece of research by Paul Ramcharan and colleagues, four skits of different restrictive practices were used by the research team to elicit responses and reflections from people with intellectual disability. In Skit 2, participants were shown a scenario where a man with disability wants to leave his home. Participants are made aware that the man in the scenario is typically able to leave his home independently, without support, but in this specific instance, he is being stopped from doing so by a member of staff. In this scenario, the staff member is refusing to unlock the door to the man's home to let the man leave because the staff member believes there are not enough staff available within the home for this to occur. In response to this scenario, the researchers noted that most participants with intellectual disability watching the skit 'expressed the view that this [set of restrictive actions by staff] led to the person getting 'angry', 'making a fuss', 'getting 'frustrated' whilst a smaller group said the person was 'frightened''.[218] This complex and multilayered set of responses to this scenario of restraint were perhaps captured best by the following person with intellectual disability who described their response to being subject to a scenario like this as follows:

> You get emotional. Take it out on somebody else. You get frustrated. It builds up in your mind.[219]

While a second person with intellectual disability participating in the research noted that:

> They want us to have a normal home but they lock the doors. That's not normal when you live at home.[220]

When these accounts from people with intellectual disability in the context of group home are read alongside the accounts presented in this chapter by other people with disability, and in other settings, they begin to sketch two of the key contours within the ecological system of restrictive practices.

First, it becomes clear that experiences of restraint, coercion and seclusion are pervasive in the everyday lives of some people with disability. Put differently, for some people with disability, restrictive and coercive practices do not simply occur in response to perceived 'behaviours of concerns', but are instead underlying, 'normalised' currents running through many of the settings that people with disability are expected to occupy. This means that while systems and institutions justify the use of restrictive practices as responses to perceived behaviours, the person themselves does not necessarily perceive these actions as associated with particular behaviours. Instead they may perceive use of restrictive practices as ongoing and arbitrary. We have noted in Chapter 1 that one serious concern with use of restrictive practices is their arbitrary nature. This violence is used on a discriminatory basis against people with disability. It is applied in a discretionary manner without clear forms of process or review. It is often applied in response to behaviour which, while not 'criminal', nevertheless attracts a sanction which would only otherwise be applied in a criminal justice context. In some cases, the sanction attracted exceeds forms of punishment used within criminal justice settings. It is notable that

for at least some people with disability who experience restrictive practices, these practices are understood as arbitrary in the additional sense that it is not clearly understood that the violence experienced is a consequence of a particular behaviour. Instead, these people experience continuing violence that is understood as arbitrary in nature, at least so far as restrictive practices are experienced as applied on a discretionary basis without any particular reference to fact or process.

Second, though related to the above first point, as the account provided by the first person with intellectual disability reiterates clearly for us, being subject to restrictive and coercive settings, where people experience a severe violation of rights that denies and injures inherent dignity, understandably makes people 'angry', 'frustrated' and so forth. And yet, as all the other accounts provided in this section have indicated, when this occurs – when a person with disability responds to a situation of restriction and coercion by getting 'angry', 'frustrated', 'agitated' and so forth – the response they appear to receive is more restraint, more limitations, more coercion. This response is concerning for numerous reasons. One of those reasons is that it is unclear how, if at all, responding to expressions of frustration about poor, inappropriate, restrictive, and/or unsupportive environments does anything to address the underlying concerns that people with disability are attempting to express about the poor, inappropriate, restrictive, and/or unsupportive environments they are subject to. Indeed, as the following accounts by parents of children with disability suggest, this response to perceived 'behaviours of concerns' does not appear to offer any response to the rights and needs of the child. As one parent put it:

> When (my daughter) was distressed she was put in a room by herself without supervision until she was picked up.[221]

With the following parent offering a similar account about their son:

> (My son) was forced against his will into the dark and sometimes physically injured in the process. For long periods of time. If he wasn't suspended he was in that room screaming and bashing his head. All the time in the dark unsupervised, as documented by the school. We have received no support, no apology, no remorse.[222]

Yet, the issue with responding to communications about unmet needs – including expressions of frustration and anger about being subject to a restrictive environment – with restriction and coercion is not simply that this response does little, if anything, to nothing about those unmet needs. Rather, these responses generate further unmet needs. These responses 'exacerbate' the challenges facing people with disability, as the following person with psychosocial disability described to the researchers in the Australian seclusion and restraint project:

> [...] if I'm isolated from the community or if I'm isolated for a set period of time, I start getting triggers and symptoms of my illness and many others have told me they do the same. When they get isolated it just exacerbates the illness further.[223]

Or as the following person with psychosocial disability explained in the recent Royal Commission into Victoria's Mental Health System, these responses can be 'counterproductive':

> In all of my compulsory admissions I was restrained, and in two admissions I was secluded as a way of protecting me from the dangerous behaviour of other male patients ... Seclusion and restraint were incredibly counterproductive and damaging for me. I think they could have been prevented if the environment had been calming, if I had not been left alone, and if a compassionate practitioner had built rapport with me.[224]

Or as another person with psychosocial disability outlined when speaking about their experiences of seclusion in a qualitative study:

> You get very depressed when you are in there [in seclusion] a long time you are completely isolated and you start to go mad because you cannot talk to anyone.[225]

Of course, we cannot help but notice the similarities between the accounts provided above – by both the parents of children with disability, and by people with psychosocial disability – and those presented in Chapter Two of this report. All these accounts speak to the ways that restrictive practices are experienced by people with disability as traumatic, violent, harmful, isolating, neglectful and abandoning. These accounts speak to the various ways that people with disability subject to restrictive practices are being stripped of dignity. Yet, what is of interest to us in this chapter, is how the accounts presented above also speak to the ways that the needs of people with disability do not appear to be met by restrictive practices. To be precise, the needs of people with disability *remain unmet* by use of restrictive practices. We explore this connection between unmet needs, expressions of those unmet needs that are interpreted as 'behaviours of concerns', and use of restrictive practices in much greater detail in the next Chapter, Chapter 4. For now, we wish to draw attention to a connected issue, which we outline now.

The above accounts suggest that restrictive practices do little to respond to the needs and wishes of people with disability. And yet, as the two case studies below suggest, for some people with disability, restrictive practices may be one of the first and only responses provided to them by some institutions and services when concerns are raised about the needs of the person with disability. The first case study, which is drawn from Queensland Advocacy for Inclusion's (QAI) report into how to return respect and control to marginalised people in the context of restrictive practices, introduces us to Michael, a 50 years-old man with disability living with his sister in Department of Housing accommodation in Queensland. Michael's case study reads as follows:

> Michael was living happily with his sister in a Department of Housing house. However due to a bureaucratic policy around department of housing tenancies a third person was moved in with them. This occurred without discussion or consultation with either Michael or his sister.

> The co-tenant became abusive to Michael's sister. This naturally resulted in Michael becoming protective of her and beginning to hit out at the co-tenant. Eventually Michael became subject to Restrictive Practices, in particular physical restraint. Michael's 'behaviour' was not explored and he was labelled an aggressor. By placing this label on Michael, no additional support was provided to prevent the escalation, nor was any consideration given to removal of the co-tenant. Rather, there was a reliance on using Restrictive Practices to manage the situation.
>
> Michael's advocate contacted QAI for assistance when the service provider requested ongoing approval to use Restrictive Practices. The Restrictive Practice order was revoked and additional supports were placed in the house to manage the situation.[226]

In the second case study – provided by the Australian Cross Disability Alliance in their submission to the *Senate Inquiry* – we are introduced to Natalie, a 50 year-old woman with disability residing in a psychiatric hospital. Natalie's case study reads as follows:

> Natalie is 50 years old and is a resident at a psychiatric hospital. She is Deaf, and has intellectual disability, schizophrenia and epilepsy. She lived with her family until her parents were unable to care for her personal needs, and then moved into a residential care facility. During the first three years, Natalie complained that a night worker was hurting her. She also began to experience delusions during this time. Her complaints were not taken seriously and Natalie eventually stopped talking about the violence. However, she began to have violent outbursts and staff reports reveal that she was restrained, sometimes for several hours, due to these outbursts. When the violence escalated to endanger other residents, Natalie was moved to the psychiatric hospital where she was placed under stricter medical supervision. At the hospital Natalie began to wet her bed at night and to pull out large sections of her hair. She was also heavily medicated. A new case manager experienced in working with survivors of sexual assault began to suspect that Natalie had been sexually assaulted. With the help of an interpreter, Natalie disclosed that for over three years, a night worker at the residential care facility had regularly come into her room and sexually assaulted her. The case manager scheduled a medical exam where it was discovered that Natalie had a sexually transmitted disease.[227]

There are four key insights to take away from reading together the case studies of Michael and Natalie. These insights are related to the themes identified above. First, in both cases, the situations and dynamics that lead up to the expression of Michael and Natalie's 'behaviours' perceived as warranting the application of restrictive practices are not explored by the service providers. The reasons why Michael and Natalie's situations, expressions of need, and broader experiences appear to have received so little consideration before restrictive practices were used against them remain unclear based on the information provided in these case studies.

Second, and returning to a point of tension previously identified in this chapter, because no consideration appears to have been paid by the service providers involved in Michael and Natalie's lives to the situations, needs and experiences of Michael and Natalie, the needs of

Michael, Michael's sister, and Natalie *remain unmet* while they are being responded to by using restrictive practices. At least in this case, restrictive practices do not respond to needs.

Third, we cannot overlook the crucial point that if the 'behaviour' that was seen as warranting a response of restrictive practices had been explored in both Michael and Natalie's cases, what would have been identified was the violence and abuse Michael and Natalie were enduring. While we cannot generalise findings from these two case studies, it is relevant to note that the Disability Royal Commission was established in part because it is understood that violence described in cases like Michael and Natalie's are not uncommon experiences for people with disability. Indeed, the Disability Royal Commission was established in part because it has consistently been found that too often, experiences of violence that have been described in cases like Michael and Natalie's remain hidden or obscured without proper investigation.[228]

Finally, what these two case examples further indicate is that if the 'behaviour' immediately preceding the use of restrictive practices had been explored, what would have also been identified alongside the violence Michael, Michael's sister and Natalie were experiencing, was the silencing and disregard of the voices and wishes of people with disability. Again, while we cannot generalise findings from these two case studies, we note that the Disability Royal Commission has commissioned a research report into accessible and inclusive complaints mechanisms at least in part because of recognition of the ways that the voices of people with disability expressing complaint with services and systems can be silenced and disregarded. Notably, in our analysis of existing data, we found several accounts of people with disability choosing not to express distress about their situation because they feared they would be subject to further restrictions. We explore these accounts in the next section of this chapter, where we examine the relationships between people with disability and those who are empowered to use restrictive practices against them in a range of different contexts.

3.2 Relationships: power-dynamics of control

The previous chapter, Chapter 2, brought attention to the ways that people with disability experience powerlessness in the context of restrictive practices. In that chapter, we shared accounts by people with disability who described how their experiences of powerlessness in the context of restrictive practices was often humiliating and dehumanising. Many of those accounts focused on how these experiences of powerlessness, dehumanisation and humiliation were connected to the segregated, closed, isolating, cruel and punitive environments that they and other people with disability are expected to endure. There were examples given of people with disability being stripped naked, strapped to a bed and left alone; being left in isolation without toilet facilities and having to urinate on themselves; having all options taken away through the experience of complete isolation through seclusion.

What is important to note about these experiences of powerlessness, dehumanisation and humiliation, however, is that people with disability do not simply find themselves in these environments. Rather, people with disability are put in these environments and scenarios by

various workers and institutional staff members, often authorised by law, who exercise much more agency on the conditions and treatment of people with disability. It is perhaps unsurprising then, that in the data we collected from past research, when people with disability described their experiences of restrictive practices as disempowering, dehumanising and humiliating, they also spoke to the ways that these experiences impact the kinds of relationships they have with the workers and staff who are empowered to commit these acts of violence and harm against them. In this section of this chapter, we consider these relational dynamics.

For some people with disability, being subject to restrictive practices by workers and staff members removes any trust or faith that a person could hold with those specific workers or staff members, and more broadly, the organisation or service in which they are subject to restrictive practices. As the following person with psychosocial disability who was subject to restraint in an inpatient mental health facility explains:

> It left me with ... a total distrust ... a total vote of no confidence and no faith in anything they did, wanting to have absolutely nothing to do with any of them ... all the time this is in my mind how they've treated me and how they treat other people, and obviously that affects relationships with them.[229]

Similar sentiments of distrust and broken relationships were described by the following children and young people with disability, who were asked how they would feel if they saw their teacher restrain another student:

> Researcher: Would seeing your teacher restrain a pupil affect how you feel about your teacher?
>
> Jordan 0.36A: I would feel scared, anxious and that kind of stuff […]
>
> Jordan 0.36A: He wouldn't like him [the teacher] because if you're getting held and its too tight e you don't like being held and you get red marks on your wrists.
>
> […]
>
> Researcher: Would you forgive your teacher if you were being held?
>
> Carlos 0.00B: No!
>
> Dev 0.00B: No.
>
> Archie 0.02A: Never-ever-ever.[230]

This theme of never being able to get out of your head how you've been treated by workers or staff who are empowered to hurt you, never being able to forgive someone for treating you or others in this way, was also expressed by the following person with intellectual disability, who characterised their experience of restrictive practices as having everything taken out of them:

> angry – makes [me] more angry. I was just shouting, thinking of hitting people again. When you have got people holding you, you kick off more than you have done. 'Smash up' That's what I feel like. It had taken everything out of me. I was going to hang [myself] so I could come back and haunt them.[231]

The above account provided by this person with intellectual disability bears strong similarities to the accounts previously presented in section 3.1 of this chapter. Like the accounts presented in section 3.1, this account offers insight into the ways that being subject to restrictive and coercive settings and practices understandably makes people feel 'angry', 'frustrated', 'agitated'. Moreover, like the accounts presented in section 3.1, this account further speaks to the ways that being subject to restrictive and coercive settings and practices directly precipitates scenarios where a person with disability may 'shout', 'kick off more', 'smash up'. And yet, as we know from the accounts presented in section 3.1 above, when a person with disability describes, as above, their own behaviour as 'shouting', 'kicking off more', 'smashing up', these responses can be perceived by workers and staff as 'behaviours of concern'. Indeed, as previously explained, when this misunderstanding in perception occurs, the result can be workers and staff responding to perceived 'behaviours of concern' with more of the same: more restraint, more control, and a denial of the dignity of the person with disability.

Crucially, for some people with disability, knowing that any expression of frustration, agitation, or anger they make about their experience of restrictive practices may result in more restraint, more control, more denial of dignity, can lead to a process of self-enforced silencing. Accounts of this process of self-enforced silencing – and the perceived necessity to do so to avoid further restrictive practices – were primarily presented in the context of mental health settings, and were captured aptly in the following account by a person with psychosocial disability, who explained:

> I just became so distressed that I didn't speak and stopped talking and just stopped moving and just thought maybe if I just keep still enough they'd come in eventually and let me out and by the time I was out I didn't dare talk to anyone or do anything, you know, cause I was frightened I'd go back in.[232]

Several other people with psychosocial disability whose accounts we collected referred to this perceived necessity to self-silence – to not express particular responses to the restrictive and coercive environments and encounters they are subject to – as part of 'playing the game' with staff. As the following person in an inpatient psychiatric service put it:

> It involves staying quiet and not retaliating or challenging staff … they are the ones who call the shots … it doesn't matter about right or wrong … you either have the power or you don't and the people who have the power impose their version of events, which will always be held above the people who don't have power.[233]

Or similarly, as Joseph described in an ethnographic study of psychiatric ward life:

> […] I don't think freedom should be restricted but yeah obviously that's the game they play and that's the game you have to play and that's why like I said 'I'm playing their game now' innit cos I've done everything they wanted, they basically raped me […] they raped me by taking everything that I said I didn't want to give basically.[234]

Crucially, as Sarah, another person with psychosocial disability from the same ethnographic study explained, no matter what she does in relation to staff, there is never a chance for her to 'win' this game because 'as a patient you're never going to win.'[235] Indeed, as Daniel, a First Nations man explained in the context of his experiences, just expressing yourself can sometimes be enough for staff to place you back in seclusion and put you back on medication:

> I came back to the ward and I started getting noisy and that. I wasn't violent, I was just angry. So they put me in seclusion and gave me a needle.[236]

These accounts emphasise the power imbalance within some mental health, education and disability residential services settings. They highlight, as discussed above in section 3.1, the 'arbitrary' nature of power relations and violence within these settings: 'it doesn't matter about right or wrong' because in these contexts the discretionary power of institutions and their staff prevails over people with disability. Once again, as described above in section 3.1, the person who experiences restrictive practices may have no perception that these practices are in response to particular behaviours. Deep power imbalances exacerbate this sense that power and violence are exercised in arbitrary ways.

While the above five accounts provided by people with psychosocial disability illuminate the unwinnable 'game' that some people with psychosocial disability believe they are forced to play with staff in mental health settings, in the context of education settings, parents of children and young people with disability often described another 'game' they felt they were forced to play. This 'game' revolved around the enrolment of children with disability in school. To this end, we found several accounts of parents with disability being told by the principal of their child's school that for their child to attend school, and remain enrolled, the parent would need to subject their child to chemical restraints. Two examples of such accounts are provided below:

> (My son) is currently being sedated to attend school. The school says he is doing well. His doctors say he is suffering a huge amount of emotional distress due to his education.[237]

> I have been told (my daughter) cannot attend school without taking Ritalin and also that she must obey whether she likes it or not or she will have her enrolment reviewed.[238]

We find the above two accounts by parents of children with disability indicative of a core dynamic operating within the ecological system of violence against people with disability where restrictive practices are used, especially when read alongside the five previous accounts provided by people with psychosocial disability. Indeed, when read together, these accounts

help to illuminate an ecological system that is characterised by uneven power-dynamics and coercive relationships between staff and people with disability. This is an ecological system where staff at various institutions are not only empowered to use restrictive practices against people with disability, but because of this power-dynamic, people with disability feel they must 'play the game' set out by staff or risk having even more being taken away from them.

It is of course necessary to note that not all accounts we collected of people with disability that described elements of the uneven power-dynamics and coercive relationships between staff and people with disability reflected a decision by the person with disability to 'play the game' of abiding by the wishes and expectations of staff. Indeed, we found one account of a person with psychosocial disability in a forensic psychiatric inpatient setting who refused to leave the seclusion room when requested by staff, and instead, openly masturbated. When this person was asked by the researchers of the study why he acted in the ways that he did, the man explained:

> 'Cause I think that's the thing, if you're in an environment that is controlled on every level, yeah, I think, in a way, it creates behaviours in people, yeah, 'cause they need some –everyone needs a level, some people are comp, complete control freaks, yeah, and need every aspect of their life controlled, to have control of it, yeah? But then, then you're in an environment where you don't have any control, everybody's trying to grab that little bit of control.[239]

We find the above account by this person with psychosocial disability in a forensic setting important for at least three reasons. First, it echoes the core contention illustrated in Section 3.1 of this chapter: restrictive and coercive environments are important dynamics in behaviours people enact in as a response to those ecologies. Second, this person's account suggests that even when a person with disability does not play the game in a way that is expected of them, they are still unable to fully shift the uneven power-dynamics they are subject to. As the person's account suggests, they can only try to 'grab that little bit of control' in an environment that is 'controlled on every level'. Finally, and related to this last point, we find this account important because it raises an interesting point for consideration: in an environment that is controlled on every level, 'everybody's trying to grab that little bit of control'. As we explore in the next section, this can include staff who are trying to take control of what they view first and foremost as their work environment.

3.3 Workplace convenience and institutional cultures of secrecy

In the previous section of this Chapter, Section 3.2, we were presented with several accounts by people with disability that described the uneven power-dynamics and coercive relationships between staff and people with disability at various institutions. Those accounts spoke to the ways that some people with disability feel they must 'play the game' set out by staff: that they must fully submit to the wishes of staff, or risk having more of their freedom taken away by staff through use of restrictive practices. In this section of the Chapter, we expand our gaze, looking beyond the

immediate relationships between people with disability and staff working at various institutions, and consider the *institutional* culture within which these relationships are formed. What happens when we broaden our gaze in this way, as will be illuminated below, is that we catch sight of an enveloping culture of workplace convenience. We catch sight of an institutional culture where the efficient running and priorities of the workplace appear to influence staff decisions to use restrictive practices against people with disability. The influence of this institutional culture was described explicitly to the Royal Commission into Aged Care Quality and Safety in the following account from a friend of an aged care resident. As this person put it, some people with disability appear to be subject to restraint simply because it makes things 'easier' for staff:

> While many of the staff seemed caring, one day I arrived to find [name removed] in a chair with a bar put down across it. She kept trying to get out and sliding down. She seemed distressed. She was effectively trapped in the chair and could not get out.
>
> One of the staff came along while I was trying to work out what was happening and said that it was 'easier' to do this at change of shift, to stop [name removed] 'wandering'.[240]

But it is not just in the aged care context that we catch sight of this culture of staff convenience. Rather, as a submission made by Children and Young People Australia to the Special Rapporteur on the Rights of Persons with Disability in 2016 suggests, we can see a similar emphasis on using restrictive practices for the purposes of staff convenience in the school context too. As the following account by a parent of a child with disability in that submission to the Special Rapporteur attests:

> (My child is) often given medicine to restrict movement when teachers can't place him where he needs to be.[241]

In both accounts above, restrictive practices are being used by staff because they believe doing so will make specific components of their work easier. In the first account, the person with disability is being mechanically restrained – that is, trapped in a chair, in distress – because staff believe this action will make their shift change easier. In the second account, the child with disability is being coercively medicated – that is, effectively trapped without movement in their body – because again, staff appear to believe that this action will lead to a more favourable outcome for the running of the class.

Importantly, in the data we collected from past research, there were also examples of restrictive practices being used against people with disability because this was perceived as making work easier for staff *in general*. Take for example, the following extensive case study of the experiences of a child with disability, Noah, and their parent, Rosie, which was presented in the Interim Report of the Disability Royal Commission:

> Noah is almost a teenager and is home-schooled by his mother, Rosie. This isn't by choice; it's because Rosie believes there is no other safe option. In her submission, Rosie told us that Noah's experiences of specialist and mainstream schools have left him with significant

trauma. Rosie believes the education system has let him down. ‘They were supposed to protect, encourage and build self-esteem yet it crushed him.’

Before the bullying started at school Noah was a ‘happy, witty, energetic, fun loving child,’ said Rosie. Noah has autism spectrum disorder, attention deficit hyperactivity disorder and a mild intellectual disability.

His first school was a specialist school. When Noah complained of bullying the school said it was ‘all in his head’. They continued to deny there was a problem even after Rosie witnessed Noah ‘being held up against a fence with another child laying into him’.

Rosie moved Noah to a state school. However, not long after he started, the school complained that his behaviour was ‘putting the class into lock down’. ‘When I was called to come and collect him I found [Noah] locked in a small room,’ said Rosie.

Rosie knew there had to be a trigger for Noah’s behaviour because it wasn’t happening at home, but the school blamed Noah and suspended him for two weeks. This would happen regularly and became a ‘vicious cycle’.

‘I know my child isn’t perfect but [he] doesn’t act out for attention or for the fun of it.’

When a teacher told Noah ‘he was a horrible person and no wonder nobody likes him and that even your mother doesn’t like you’, it was obvious to Rosie that he was being bullied by the teacher and students.

Rosie told us the school asked her to medicate Noah, but she refused. Instead she enrolled him back into the specialist school, feeling she had no other choice.

When the behaviours started again Rosie decided to attend all excursions and events ‘to figure out what the triggers were’. When students did things Noah didn’t like he would say, ‘stop it, I don’t like it’ or ‘you’re annoying me, leave me alone’. But Rosie saw the children ‘ignore his pleas and keep doing what theywere doing’.

When she brought this to the teacher’s attention they suggested Noah be ‘medicated so he was more accepting of other students’ behavior’. Rosie reluctantly agreed and ‘it was the worst decision I ever made.’ Her happy, witty boy disappeared and Noah became ‘a zombie’. He put on 40 kg and the behaviours didn’t stop.[242]

This case study of Noah’s experiences of restrictive practices as told from the perspective of his mother, Rosie, is important for five reasons. First, Noah’s case study is reminiscent of one of the key tensions we highlighted in section 3.1 above when considering the case studies of Michael and Natalie. Noah’s case study offers another example of a person with disability who is experiencing violence and abuse which remains ignored and unaddressed. By this we mean, Noah is experiencing bullying at school. He is seen by his mother as ‘being held up against a

fence with another child laying into him'. He is being told by his teacher – an adult in authority – that he is 'a horrible person' and that no one likes him. Noah is also making repeated requests for this bullying to stop. He is seen by his mother to ask his fellow students to stop what they are doing, and to leave him alone. However, his pleas are being ignored, and, when he and his mother complain to the school about these experiences of bullying, he is told that it is 'all in his head'. Put simply, both Noah's experiences of harm and his requests for assistance are being ignored. What does not appear to be ignored, however, are Noah's apparently unexplainable 'behaviours', which the school responds to with restrictive practices. In this way, Noah's case study does not simply offer another example of a person with disability who is experiencing violence and abuse which remains ignored and unaddressed, but also an example of how the violence and abuse some people with disability experience can be further obscured and ignored by use of restrictive practices.

Second, Noah's story also offers another illustration of the ways that using restrictive practices against people with disability is cruel and harmful. Indeed, like so many of the accounts of other children and young people with disability described in Chapter 2 of this report, Noah's case study is yet another description of a child with disability who is being locked in a small room and left alone, presumably for an extended period. We are also being provided with an account of a child who is being forced to take drugs that turn him into a 'zombie' and make him gain significant weight. As the beginning of the case study states, these experiences have left Noah with significant trauma.

The previous point on trauma relates to a third key insight that can be taken from Noah's story. Much like many of the other accounts shared in Chapter 2, Noah's experiences of restrictive practices offer insight into the ways that these practices hold life-altering and life-long effects. What Rosie's observations of her child over time make clear, is that Noah's experiences of being subject to restrictive practices turn Noah from being a 'happy, witty, energetic, fun loving child', into a child that is traumatised. Noah is turned into a 'zombie', into a teenager who has gained significant weight, which may have future health ramifications.

Fourth, like some of the accounts presented in section 3.1 above, Noah's case study offers another account of a parent who feels they have no other choice but to unenroll their child from school because of the harms their child is being subject to in these settings. Noah's case study is another example of how to protect a child from the trauma and life-altering violence and harms of restrictive practices, the only 'option' left for some people with disability is to have even more choices removed, even more restrictions on their life applied, even more taken away.

And yet, fifth, what is perhaps made apparent in Noah's case study in a way that was not as clear in any of the other accounts previously considered, is how in Noah's case, restrictive practices are being used to *make the school environment easier and more convenient for everyone else other than the person with disability*. Noah, a child, is being locked in a small room, alone, and presumably for an extended period because his apparently unexplainable behaviours disrupts the running of the class for teachers and other students. Noah is being coerced to take drugs that turn him into a 'zombie', are associated with significant weight gain,

and appear to have no positive effect, for the purposes of making Noah 'more accepting' of the bullying he is experiencing by his classmates, and thus, presumably, less likely to complain or act out in a way that might disrupt the running of a class. In these ways, what we gain from Noah's case study, especially when considered alongside the other two accounts immediately preceding this case study, is partial insight of another dynamic within the ecological system of restrictive practices. If restrictive practices are sometimes being used to make the work of staff at institutions easier, to enable the work of staff to run unchanged and without any perceived disruptions, then what we are beginning to see is an institutional culture where the efficiency of the job is being prioritised over recognition of the rights and needs of people with disability. This potential prioritisation of staff needs or desires over those of the person with disability was also expressed in the following account of Bob, a person with psychosocial disability subject to restrictive practices in an inpatient psychiatric service.

Bob describes how the nurses on the ward appear to be more interested in ensuring they meet the workplace expectations surrounding the role of caring for a person who is at risk of suicide than they do of caring for the person. As Bob put it:

> They [nurses] were only interested in what pills they could give me. The HCAs [health care assistants] weren't interested [about why this had happened], just wondered 'how can we stop this guy from killing himself' and 'how many obs [observations] have we got to do' … I mean, it would have been better to talk to someone about the whole experience, but it didn't happen … I would have preferred someone to talk to.[243]

We find Bob's account indicative on two interrelated fronts. First, Bob's account offers indication of some of the other ways that some people with disability experience restrictive practices and other restrictions on their freedom as a means by which staff at institutions can make their work easier, efficient, or simply, undisrupted. Bob, a person with psychosocial disability experiencing distress, is not being spoken to, listened to. Instead, Bob is being met by nurses who only appear interested in ticking off the requirements of the job of preventing suicide: give pills, perform a set number of observations. Yet, what Bob's account also offers is indication of how this broader ecological system of institutional efficiency, of workplace prioritisation, contributes to the dehumanisation of people with disability we described in 2.4 of Chapter 2.

This connection between operation of the workplace and dehumanisation of people with disability was further articulated by a person with psychosocial disability in the Australian Seclusion and Restraint Project. In speaking to the researchers for that project, the person with psychosocial disability expressed this point as staff 'forgetting that we're actually people', as they explained to the researchers in the context of mental health settings:

> I think people are just so busy and under-resourced, there's complacency and desensitisation ... we see it so often ... Desensitisation like forgetting that we're actually people.[244]

We return in Chapter 4, section 4.3, to further explore the connection between restrictive practices and under-resourced settings. For now, what we find important about both the above person's reflections on the connection between the operation of the workplace and the dehumanisation of people with disability, and the previously provided accounts of Bob and Rosie, is that together, these accounts prompt the question: how has it become possible for restrictive practices to be used in this way? Or, put differently, what elements or dynamics in the ecological system of restrictive practices mean that restrictive practices can come to be used as a matter of workplace convenience and efficiency? While we do not have the dataset available to answer this question fully, we note that there were at least two indications of potential answers provided in the experiential data we collected from past research.

First, it appears that in some instances, restrictive practices can come to be used as a matter of workplace convenience and efficiency because this is simply how these workplaces have come to operate over time. Or, put differently, treating people with disability in this way – forgetting people with disability are actually people – appears to have become an accepted, unquestioned part of the workplace culture in some institutions. Take, for example, the following account provided to the Royal Commission into Aged Care Quality and Safety by a woman about her husband who resides in an aged care facility:

> I sign permission for [name removed] to have a seatbelt on his wheelchair, expecting it to be used only when he is in transit. I am assured that it will not be left on him all day, but every time I go to see him, at different times every day, he is strapped down. It looks like the staff, at each new shift, just leave him as they find him. He is trussed tightly around his legs and body, the strap in the middle biting deeply into him. This makes it extremely difficult for me to take him to the bathroom, or for him to eat at table. He has no exercise, and his mobility is affected. He is constantly agitated, asking me and others to set him free.[245]

Or, in a similar vein, the following account provided by a person with psychosocial disability who is speaking about their experiences of seclusion. That person explained:

> They [staff] never specified any time limit that I should be in there. When day staff came back on I was let out, there was no reason that I was let out then and not six hours before, it was just convenient for them [staff] and that's wrong.[246]

In both the above examples, the people with disability in question are being stripped of their dignity because at each new shift, the next set of staff members simply appear to accept the scenario they are presented with. To be explicit, in the above situations, each new staff member is being presented with a scenario where a person with disability is being painfully strapped to a wheelchair asking to be set free, or a person with disability has been left in seclusion for an extended period, and, looking at this scenario, these staff members do not appear to question what they are seeing, and indeed, appear to gain some benefit from leaving things unquestioned and unchanged.

Notably, in the experiential data we collected from past research, we found several examples of parents, partners, and other supporters of people with disability who also encountered a culture of silence when asking questions about the abuse their loved one experienced. This culture of silence offers a second potential answer to the questions raised above. Indeed, what we saw most often in the data we collected, were accounts of parents of children and young people with disability who were not only dismayed that their child had been subject to restrictive practices in a school setting, but further shocked that the school who was responsible for their child's wellbeing during school hours had never told them that coercive and non-consensual measures had been used. Instead, in many of the cases we found, the only reason that the use of restrictive practices against the child or young person with disability eventually came to light was because the child spoke to their parent about what they had experienced, as exemplified in the following accounts by three different parents of children or young people with disability:

> (My daughter was) placed in a dark, small room in the previous year on two occasions for being aggressive. I was not told this occurred – my daughter told me. She was in the room alone.[247]

> My son came home from school very distressed. Once I finally managed to calm him down he told me he had been pinned to the ground in a prone position by multiple staff members at school. I was not informed that a restrictive practice had taken place. He did not have a behaviour support plan in place at the school. This is not acceptable. He has been traumatised ever since.[248]

> My son came home upset after school one day and told me the learning support teacher dragged him by the leg whilst hiding under a table. The school did not report this incident to me. Apparently, he was wanted access to the computers and was not allowed to. Rather than give him some space and time to accept this, he was boxed into a corner by the teacher which felt threatening so he hid under a table. Again rather than keeping calm and giving space to allow for reasoning and self-regulation, the teacher chose an antagonising approach which only made things worse. My son was grabbed by the leg and dragged along the floor. My son is a teenager. He felt ashamed and still does when in this teacher's company.[249]

It is important to keep in mind, however, that not all children or young people with disability are able to communicate their experiences of abuse to their parents or others; this point was emphasised by the Royal Commission into Institutional Responses to Child Sexual Abuse.[250] Moreover, some children with disability might not have parents who have the capacity or social capital to advocate for their children. Indeed, some children might be in the care of the State, and thus not have a parent with whom they can confide. Here we note the Royal Commission into the Protection and Detention of Children in the Norther Territory provided examples of children in out-of-home-care telling their out-of-home-care workers or other government department workers about being harmed, with no further action taken by these workers.[251] Thus, some of the most disadvantaged children with disability might be even more marginalised in the context of the dynamic of parental advocacy against use of restrictive practices.

Sometimes, as the account below by another parent implies, the child may simply not report what has occurred to them. In such a situation, the only way the coercive and non-consensual measures the child experiences will come to light is if another person who witnesses the situation comes forward, as the following parent of a child with disability explains:

> After being dragged by staff (my son) was put in a fenced-in outdoor area by himself in the middle of winter without a jumper. The staff even closed the blinds so he couldn't see into the room. He was terrified and banging on the door begging to be let back in as witnessed by another parent. The school didn't notify me about the physical restraint nor the locking him outside alone. I was told by another parent.[252]

It is also important to note that sometimes, as the following account by another parent reminds us, some children or young people with disability will have communication limitations that can also obscure the abuse some children and young people with disability are experiencing:

> In May 2013 I discovered, from limited clues my son gave me, that he had been held in a "time out room" on many occasions throughout the beginning of that year. Due to his poor expressive language he had not been able to tell me what had been happening. As a family we were totally devastated when we discovered what had been happening. The school acted well outside of Departmental guidelines ... we were NEVER informed when such methods were used, despite written requests demanding to know the full circumstances.[253]

And, sometimes, as the following account of Jane provided in the Australian Cross Disability Alliance's 'personal stories and testimonies' submission to the *Senate Inquiry* makes clear, some parents of children and young people with disability may have to resort to freedom of information requests to breach the silence that surrounds their child's abuse:

> In 2014, Jane found out through a Freedom of Information request that her 8-year-old son, who has Autism had been locked in a room smaller than an accessible toilet, two out of every three days, 2–3 times per day while attending his school. He had also been subjected to physical restraint. The documents setting this out had been kept from her.[254]

When read together, these parents' accounts of their and their child's experiences offer glimpses of an enveloping circle of silence and secrecy that surrounds use of restrictive practices. This is an enveloping circle where the violence of restrictive practices is neither questioned internally, nor enabled to be questioned externally. Or, put differently, an enveloping circle which suppresses questioning of restrictive practices.

Of course, we acknowledge that it would be easy to assume that this enveloping circle of silence and secrecy is unique to school settings. And perhaps, to an extent, there is something unique about the role and operation of schools in society that enables this silence and secrecy to take shape in the way described by the parents in the above six accounts. However, we note that in the data we collected from past research, we found similar examples of this silence and secrecy operating in non-school settings. For example, as part of the recent Royal Commission

into Aged Care Quality and Safety, Rosemary Cameron gave the following evidence about an incident involving her husband, Don Cameron who lived with Lewy Body dementia:

> I found him face down on the floor, out to it. And ... he was so heavily sedated, they had left him in an upright chair in the lounge area and he had just fallen forward out. His face was quite bruised, and he was in a really bad way. And often when I would ask, 'Has he had any extra medication?' I would be told that they, no, they didn't think so, that he had just had a bad night, and he was very tired. But then when I would check closer and ask to see what the medications had been I would find that that was quite different, that he had, in fact, had extra.[255]

To us, this additional account of Don's experiences of restrictive practices helps us to appreciate how silence and secrecy form part of the broader enveloping ecological system within which restrictive practices operate, regardless of the specific setting within which the person with disability resides or receives services or supports. We note that these observations are in line with scholarship and inquiries which have highlighted the way in which institutional environments generate cultures of silence in relation to violence. For instance, the Royal Commission into Institutional Responses to Child Sexual Abuse drew heavily on research that highlighted the impact of institutions upon internal cultures, drawing attention in particular to work by sociologist Erving Goffman on so called 'total institutions.'[256] That Royal Commission provided the following definition of total institutions, and made note of their relationship with cultures of secrecy:

> Examples of total institutions identified in the research literature, some of which are institution types we heard about during the course of the Royal Commission, include boarding schools, immigration detention centres, military academies, youth detention facilities and children's residential institutions. However, the degree to which institutions display the characteristics of a total institution can vary. Commissioned research suggests that these institutions tend to conduct their operations in secret. The consequence of total institution cultures is that they can impede detection of and undermine appropriate responses to child sexual abuse when it occurs.[257]

The impact of an institutional environment upon the internal culture was understood by the Royal Commission into Institutional Responses to Child Sexual Abuse as significant.[258]

Findings such as this raise questions about consequences. Specifically, what are the consequences for staff and workplaces that use restrictive practices as a matter of convenience? What are the consequences for staff and workplaces who keep the truth from parents, partners and loved ones about what is taking place? As we explore in the next section on the broader socio-legal norms that envelop and enable all the dynamics described in this chapter, in the experience of some people with disability, there does not appear to be any consequences for staff and workplaces.

3.4 Enveloping and enabling socio-legal norms

The previous three sections of this chapter have focused on the connections between the person with disability experiencing restrictive practices, the uneven power-dynamics in the relationships between the person with disability and staff that surround and inform these experiences of restrictive practices, and workplace dynamics and cultures that feed into choices made by staff applying restrictive practices. In this final section of the chapter, we take a step back, look again, and bring into view some of the broader societal norms and expectations that appear to envelop these connections. In so doing, we catch sight of two important dynamics within the broader ecological system of violence against people with disability, which we describe below.

The first dynamic relates to the consequences for those people who use restrictive practices against people with disability. At the present moment, there are little to no consequences for staff who use restrictive practices against people with disability. This is because, as will be discussed in significant detail in Chapters 4 and 5 of this report, at the present moment, restrictive practices are permitted and regulated via law and policy. What is apparent from the sample of experiential data we collected from past research, is that for some people with disability, the lack of consequences for the harmful, violent actions that are being perpetrated against them appears to occur because the harm that has been perpetrated through the use of restrictive practices is not recognised. Take for example, the following account of Eddie that the Australian Cross Disability Alliance provided in their 'personal stories and testimonies' submission to the *Senate Inquiry*:

> Eddie is a 35 year old with intellectual disability. A disability advocate visited his home on a tip off from a service provider that he needed support. On entering the home the advocate found that Eddie was being kept captive in a cage with three solid walls and bars on the fourth. His carers only allowed him to wear adult nappies and his diet consisted solely of mashed banana, milk and cereal. Family members used a plastic pipe to prod him through the bars. It's not known how long he has lived like this. When the advocate made further inquiries he discovered that police had visited Eddie and found nothing wrong.[259]

In this case study, Eddie is being subject to cruel, degrading and inhumane treatment; treatment which is reminiscent of many of the other experiences of restrictive practices described in Chapter 2 of this report, and which arguably would cross the criminal law threshold of assault. And yet when police visit Eddie, they determine that nothing is wrong. The police seemingly determined that there was nothing *illegal* about what was being done to Eddie under current legislation. This technicality about legality and the consequences it holds for both people with disability and those empowered to use restrictive practices against them was picked up by Chris, a person with psychosocial disability, who was subject to restrictive practices in a psychiatric ward. As Chris reflected:

> yeah, and they won't go to court either [for using restrictive practices …] what they've done is allowed nothing will happen to them they'll keep on, they just doing their job […] well I think it's disgusting.[260]

What is being described in Chris's reflections and the case study of Eddie is a longstanding issue that has been raised repeatedly by Disabled People's Organisations. It is also an issue that was recognised in the following concluding committee review provided in the final report of the *Senate Inquiry:*

> The committee is highly disturbed at the evidence presented of restrictive practice. Clearly, in many cases what is deemed to be a necessary therapeutic or personal safety intervention is in fact, assault and unlawful deprivation of liberty.[261]

We return to this issue of legality in Chapter 4, and again in Chapter 5. For now, in this Chapter, we seek only to make the following key point: staff acceptance of using and seeing as acceptable harmful, violent, traumatic practices against people with disability occurs in a broader socio-legal context where such harmful, violent, traumatic practices are not recognised as violence by law, nor dealt with accordingly through criminal justice processes. Thus, not only are people with disability dehumanised to the extent they have no place in settings purportedly designed to support and enrich them – as illustrated by the earlier example of Noah – but this is then compounded by their erasure from justice processes that are designed to protect and remediate violence when it occurs.

As discussed in Chapter 1, the CRPD places strong obligations under Article 5, 12 and 13 to prohibit discrimination and ensure equality before the law and equal access to justice. Further the CRPD stresses that people with disability are owed equal rights to protection from violence, as articulated by Articles 14-17 of the Convention. These rights to protection from violence oblige States to take 'all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment' and further 'to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse.'

And yet, in an almost contradictory, at times perverse way, some people with disability's experiences of restrictive practices *are* encompassed by law and justice, whereby they are exposed not to protection and redress, but to criminalisation and punishment. Of issue here is the point that not only can the criminal justice system not offer protection from violence for people with disability subject to restrictive practices, but that the criminal justice system can further be complicit in the use of restrictive practices. Indeed, some people with disability see the criminal justice system as part of the continuum of violence they experience.

Perhaps the most striking example of the almost contradictory, complex nature of this dynamic is provided in the following excerpts from Peter and Daniel. Peter and Daniel are two First Nations peoples with psychosocial disability. Both Peter and Daniel experience anger and confusion when police were used to remove and transport them from a mental health

setting into seclusion. In Peter's case, he is being removed by police from hospital to seclusion. Peter describes the tension surrounding police involvement in this process in the following way:

> And I thought being Indigenous patient and all that, I thought the cops, the police, didn't have authority to do that. It's got nothing to do with them. They treated me like a criminal. The only, I think the only things makes me wild and angry is the Queensland coppers, that's all, nothing else, not the mental health things or case managers . . . You can wear Tupac t-shirt and they [the police] think you're a criminal.[262]

In Daniel's case, he is being removed by police from community care into hospital, where he is subsequently placed into seclusion. Daniel describes this experience as follows:

> I came back drunk [to community care] and I wasn't allowed to be drinking so they called the coppers … I was pissed off coz the nurses rang the police; it didn't have nothing to do with them. They psychiatric nurses could have done it. And the nurse thought I was arguing about when they put me in the car. I was saying to the police 'this has nothing to do with you, this is a psychiatric matter, psychiatric nurses should be here to take me back.' … Yeah [the police where he was going into seclusion] said 'take off all your clothes, put the gown on' … Like I was a prisoner, like I was a prisoner of some sort![263]

We find the examples of Peter and Daniel provided above illuminating on at least two fronts. First, they offer insight into some of the ways that the broader justice system envelops and enables use of restrictive practices against people with disability while at the same time refusing to acknowledge and address the violence and abuse that people with disability subject to these practices are experiencing. Second, these examples act as important reminders of the long histories of unacknowledged and unaddressed violence that some people with disability experience.

While Peter and Daniel's accounts speak to the broader socio-legal dynamics encompassing restrictive practices that sees police enabling use of restrictive practices (i.e., not prosecuting the violence these practices entail), police and criminal justice only form one part of this dynamic. Indeed, what was more common in the experiential data we collected from past research, were examples of the ways that restrictive practices are enveloped and enabled by other disability-specific laws. In particular, there were several examples provided in the data we collected of the enabling role that guardianship orders (made under guardianship law) play in enabling violence against people with disability. Before we consider these examples, it is necessary to reiterate as we did in the Introduction Chapter of this report, guardianship orders are in and of themselves restrictive and coercive practices, as is apparent in the case study of 'X' below, which was provided by Advocacy Tasmania in response to the Disability Royal Commission's *Restrictive Practices Issues Paper*.

In the case of 'X', a guardianship order is sought and secured by the hospital to override the rights and intentions of X, with the subsequent consequence being that X becomes subject to further restrictive practices:

> X has modern mobility impairments associated with her condition, but no identified impairments in her mental or decision-making capacity. She sought advocacy support when, after a stay in hospital to recover from an injury resulting from a fall, she had been denied the right to discharge herself from the hospital to return home.
>
> X reported that when she had requested to leave, she had been put off repeatedly by the hospital doctors, who said they would organise things. When she asked for her discharge papers, X was assigned a sitter by the hospital to ensure she did not leave.
>
> X and her advocate were told X was under a duty of care order, which is not an existing legal order type in Tasmania. The advocates or urgent legal support for X which determined that X was under no legal orders at that time, and that she had the right to be discharged.
>
> When X attempted to leave the hospital, accompanied by her advocate and under legal advice, hospital security was called, and X was threatened with a code black [physical and chemical restraint]. X was unwilling to risk being physically and chemically restrained and elected to wait, at which point the hospital applied for an emergency guardianship order.
>
> Despite no previously identified impairments in X is decision making capacity, the low evidence bar for medical evidence for emergency guardianship orders in Tasmania meant that the 28-day order was granted, and X was restricted from leaving the hospital.
>
> X attempted to appeal the emergency order, but was unable to access the appropriate Supreme Court mechanisms to do so within the 28 days of the emergency guardianship order.[264]

A similar scenario played out for Danny in the case study below. In Danny's case, an application for a guardianship order was sought because Danny was fighting an eviction notice he had been provided by his disability support and housing provider. As detailed in the case study of Danny:

> Danny lived in community housing, that also provided disability supports, for a number of years. Danny was having issues with his housing provider and they sent him an eviction notice stating he did not meet the criteria for their housing program. Danny felt they were evicting him because he complained about how they treated him, and he was fighting the eviction. An application for Guardianship was made on the grounds that Danny could not manage his accommodation. A Guardianship order was granted despite there being no clear evidence that Danny could not manage his own affairs. Danny was able to have the order removed but not without considerable time and effort.[265]

A guardianship order is also sought in the case of Tina, below. This time the application appears to be sought to restrict Tina's access to family members who were questioning a service provider's use of restrictive practices against Tina. As the case study describes:

> Tina was being supported by a service provider who regularly sought to increase the range of Restrictive Practices they could use around Tina. As a baseline, Tina was contained for 16 hours per day and secluded for eight hours overnight. During the day she would also be placed in seclusion or have chemical restraint applied to control her behaviour.
>
> Tina's behaviour arose because neither she nor her family were listened to. Tina was bored, had little meaningful activity in her life and had been isolated from the community in which she lived. The service provider showed little interest in addressing these issues when they were raised by the family. Instead, they attempted to restrict Tina's access to her family and on several occasions applied to QCAT to have the public guardian appointed, as opposed to the family member. The service provider refused to acknowledge that Tina's behaviour was a form of communication (expressing dissatisfaction) and labelled Tina as difficult and prone to 'challenging behaviours'.
>
> Tina really wanted to move to her own place and be closer to her family. The service provider discouraged this dream. Rather, they made application to QCAT submitting that Tina could never live on her own, was unsafe to be in the community and needed high level use of Restrictive Practices. The family continued their strong advocacy for Tina and contacted QAI [Queensland Advocacy for Inclusion] for assistance.
>
> Eventually Tina was moved into her own residence, closer to her family and to a service provider who has never used any form of Restrictive Practices. Tina now has a part-time job and has become part of her local community. The 'challenging behaviours' have drastically reduced, as has the level of funding required to provide her support.[266]

We find the case studies of 'X', Danny and Tina illuminating on two connected fronts. First, these case studies offer yet more descriptions of the uneven power-dynamics that were first described in Section 3.2 above. Indeed, like so many of the other examples provided in Section 3.2 above, 'X', Danny and Tina all find themselves in scenarios where their wishes and needs are not only being ignored by those who are employed to provide them with services and supports, but also where their attempts to act on their wishes and needs are overridden by the additional layers of authority that providers are enabled to seek.

Second, these case studies clarify that for some people with disability, what enables their wishes and needs to be overridden by the desires of a service provider is the broader socio-legal structures and norms which envelop people with disability. Put differently, what enables the service providers to ignore and override the wishes of 'X', Danny and Tina is the capacity of these providers to access legal provisions that are only able to be applied to people with disability, whether that be through the use of restrictive practices, or, when such practices cannot be accessed directly, the restrictive practice of guardianship orders which will enable use of additional restrictive practices moving forward. We return in Chapter 4 to discuss the legality and legal authorisation pathways to restrictive practices in significant detail.

3.5 Conclusion

This chapter described the broader ecological system of violence against people with disability within which restrictive practices take shape and are perpetuated against people with disability. The chapter drew its data from scholarly literature, reports, government inquiries, and the submissions that have been made to those inquiries. Section 3.1 began with a focus on the 'individual', including perceptions of individual people with disability in this ecological system, and explored connections between restrictive practices, the unmet needs of people with disability, and what are perceived by some to be individualised 'behaviours of concern'. Section 3.2 then looked beyond the individual and explored the uneven power-dynamics in the relationships between people with disability and those who are empowered to use restrictive practices against them in a range of contexts and settings. Section 3.3 then located these relationships within their environment, exploring institutional, workplace cultures of convenience, silence and secrecy. Finally, section 3.4 considered the 'societal' elements at play within the ecological system of restrictive practices, exploring some of the encompassing socio-legal norms and expectations that enable people with disability to be legally subject to violence, and to receive differential and unequal treatment under law. Figure 3 below reflects the updated findings of this chapter in relation to the ecological system of restrictive practices.

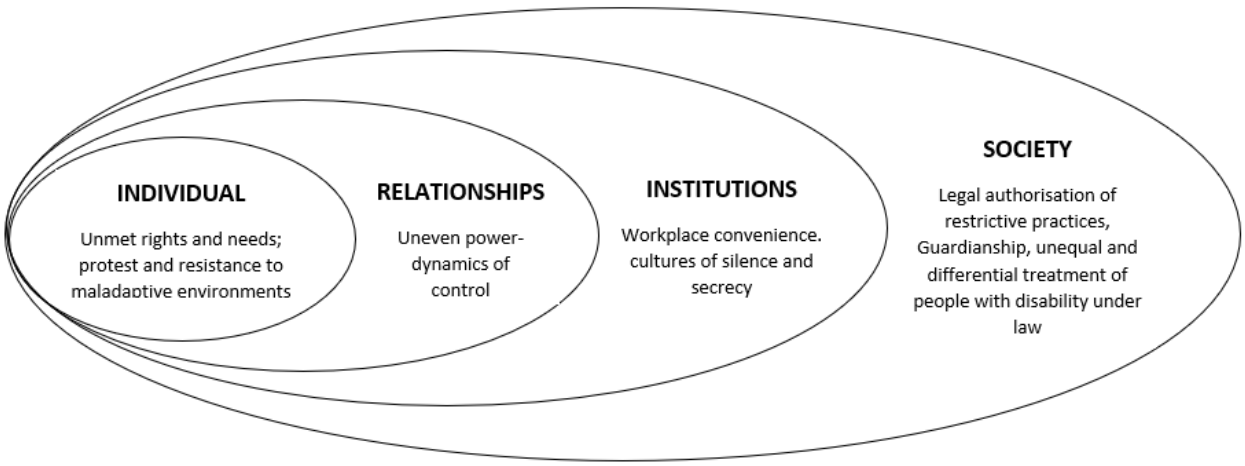


Figure 4: The ecological system of restrictive practices as identified by people with disability

Chapter 4: Systemic drivers and enablers of restrictive practices

Chapters 2 and 3 provided detailed insight into the experiences and ecological system of restrictive practices as described by people with disability and those who are closest to them. These insights offer necessary foundation on which to build understandings of why restrictive practices are used. They also provided a foundation from which to address the first research questions set by the Disability Royal Commission. In this chapter, we build on these understandings and address this research question. To this end, this chapter turns to research literature and explores what is currently known about the systemic drivers and enablers of restrictive practices. In so doing, we identify four systemic drivers as well as a core enabler of restrictive practices. We outline how these drivers and enabler interact and intersect with one another, and how they produce the experiences and ecological system described by people with disability in Chapters 2 and 3.

Before presenting the drivers and enabler of restrictive practices, it is necessary to note three dynamics that are of relevance to the Disability Royal Commission's focus on lived experience, intersectionality and human rights. First, much of the research conducted into restrictive practices over the past two decades is either comprised of administrative data about the frequency and prevalence of restrictive practices used in different settings against people with disability, or the knowledge, experiences, attitudes and development of the various workers and staff charged with supporting people with disability in these settings. It is uncommon to find research into the drivers of restrictive practices that prioritise the voices and insights of people with disability. As this chapter will illuminate, the views of professionals and staff are not interchangeable to, nor necessarily even aligned with those of people with disability who experience restrictive practices. It is impossible to discount the likelihood that power-dynamics in institutional settings, pervasive negative community attitudes about disability, and misplaced assumptions about the benevolence of restrictive practices that imbue current legal and regulatory frameworks for restrictive practices, will impact on the perspectives and experiences of professionals and staff about use of restrictive practice.

Second, and perhaps in part due to the tendency towards prioritising the views, experiences and voices of workers and staff over those of people with disability, there are several notable gaps in research literature on restrictive practices. Very little research into the drivers and enablers of restrictive practices considers the intersectional experiences of people with disability. There is, for instance, little research attending to the experiences of First Nations peoples with disability, culturally and linguistically diverse people with disability, and people with disability from LGBTQI+ communities. There are also few, if any, studies that consider the drivers and enablers of restrictive practices either in settings that are not disability-specific, or in contexts where the legal basis for restrictive practices is other than the most well-known laws such as guardianship, disability, and mental health law. Accordingly, there is, for example, almost no literature on restrictive, disability-specific, practices in out-of-home-care, immigration detention centres, or prisons.

As a result of these significant limitations in the research literature, this chapter is in turn limited. The findings presented in this chapter primarily relate to disability-specific settings – such as institutional settings, group homes, and psychiatric wards – where restrictive practices are commonly recognised as occurring, and where legislation and policy authorise and regulate the ongoing use of these practices. We have also drawn on the small collection of literature concerning drivers of restrictive practices in schools – a setting where it is commonly recognised that restrictive practices occur, but where regulation is often inconsistent or absent. What this means in practice is that it is not possible when working with the current research literature available to fully address the first research question set by the Disability Royal Commission: to determine from the research available precisely how systemic drivers of the use of restrictive practices against people with disability differ across settings across Australia. What we can and do provide in this chapter, instead, is repeated indications of from which setting specific findings about drivers have been found.

Finally, much literature that explores the use and drivers for restrictive practices comes from other countries. Thus, while there is a growing body of scholarship concerning restrictive practices in Australia, far more studies on the use and drivers of restrictive practices have been conducted in the USA, England and Wales, and parts of Europe. In this chapter we draw on this international body of work alongside the Australian scholarship. We attempt, where possible, to show the parallels or similarities between the findings presented in international scholarship with those presented in Australian scholarship, although we acknowledge that there are some limits to generalisability when moving between countries.

The chapter now proceeds through five main sections. These sections reflect the four drivers and key enabler for restrictive practices in Australia and elsewhere.

4.1 Segregation, clustering of people with disability, and institutional power-dynamics

In this first section of the chapter, we outline the research that identifies segregated and congregated environments and settings, where people with disability are clustered together, as one of the foremost drivers for restrictive practices. We further explore the institutional power-dynamics inherent to these environments and settings.

In this report, we understand ‘segregation’ as a form of group discriminatory treatment to spatially, geographically, economically, socially and/or jurisdictionally separate two groups, provide differential access to resources and opportunities, and generate status differentiation. While it is certainly possible to use ‘specific measures’ to provide forms of differential treatment to achieve equality (as per Article 5.4 CRPD), segregation in this understanding typically functions as an instrument to create and/or maintain inequality. For this reason, the concept of ‘segregation’ has a long history in the context of civil and human rights. For example, in the context of the apartheid regime in South Africa, segregation has been understood as

'a complex amalgam of political, ideological and administrative strategies designed to maintain and entrench white supremacy at every level'.[267]

In many societies, people with disability are systematically treated in different ways from the rest of the community. As Gerard Goggin and Christopher Newell state, this segregation, or 'apartheid' as they describe it, operates in a disability context as:

> partitioning those who are "able-bodied" (at least temporarily so) and those who are "disabled". There are special places, practices and accommodations that mark a line not to be crossed between "normal" and "disabled".[268]

In the context of international human rights, there has been an understanding that segregated settings constitute a form of discrimination against people with disability. The 1994 General Comment of the Committee on Economic, Social and Cultural Rights observed that 'segregation and isolation achieved through the imposition of physical and social barriers' comprised a form of discrimination against people with disability.[269] The Committee on the Rights of Persons with Disabilities notes the relationship between segregation and social exclusion. The Committee stated that this relationship with social exclusion can 'lead to violence, exploitation, abuse in addition to negative stereotypes that feed into a cycle of marginalization against persons with disabilities'.[270] The imperative to avoid to segregation is articulated in Article 19 and Article 23 CRPD.

Segregation is often interconnected with institutionalisation. This is because many forms of institutionalised treatment experienced by people with disability occur in closed settings that are also segregated.[271] While it is true that forms of institutionalisation shape the delivery of many services available to the general community – such as education or health – in many cases, the only way for people with disability to receive resources and support is through a segregated service or setting that is not available to other members of the community. It is for this reason that the Committee on the Rights of Persons with Disabilities argues that institutionalisation and segregation are tied together in ways that undermine the apparent 'benefits' provided by such institutionalised supports. As the Committee explained:

> institutional settings may offer persons with disabilities a certain degree of choice and control, however, these choices are limited to specific areas of life and do not change the segregating character of institutions.[272]

As Article 19 makes clear, choice has to be free, informed and meaningful. Indeed, the Committee on the Rights of Persons with Disabilities has stated: '[i]nstitutionalization is discriminatory as it demonstrates a failure to create support and services in the community for persons with disabilities, who are forced to relinquish their participation in community life to receive treatment.'[273] In this report we thus understand segregation as a characteristic of the institutionalised forms of treatment of people with disability. The segregation of people with disability contributes to the systematic forms of social, political, economic, cultural and legal

exclusion experienced by people with disability, and undermines the status of people with disability in our society.

Before attending to the body of evidence connecting segregation and institutionalisation with restrictive practices, we note that beyond restrictive practices, segregated and congregated environments and settings have additionally been associated with both diminished quality of life for people with disability,[274] and the broader perpetration of violence, abuse, neglect and exploitation of people with disability.[275]

4.1.1 Segregated and congregate environments and settings

The research literature is unequivocal: people with disability are subject to the greatest use of restrictive practices in segregated and congregated environments. For example, a 2005 study of the treatment and management of perceived 'behaviours of concern' in congregate and non-congregate community-based supported accommodation in England and Wales found that 'congregate settings were consistently linked to increased use of physical restraint'.[276] Crucially, the study clarified that this increased use of physical restraint in congregate settings occurred, 'despite there being no differences between the groups with regard to either staff reports of, or observational measures of, behaviours of concern'.[277]

Similar results have been found in other parts of the world. In Belgium, it was found that women with intellectual disability living in institutional settings face an increased probability of sterilisation.[278] That same study found that policies adopted by different institutions in Belgium about sexual activity (e.g., prohibition of sexual activity) are further associated with increased probability of sterilisation between institutions.[279] In the Australian context, and specifically, the state of Victoria, it has been found that people with disability receiving institutional accommodation or community-based residential services experience higher instances of seclusion than people with disability receiving other services, such as day services.[280] It was further found that people with disability living in institutional accommodation in Victoria were the most likely to be secluded in that state.[281] Finally, a 2021 scoping review of the international literature on restrictive practices in adult secure mental health services (also known as forensic mental health services) found use of seclusion, the duration of seclusion, and involuntary medication, were all higher in these secured settings in comparison to other mental health settings.[282]

Of course, while the above survey of the research literature makes clear that people with disability are subject to the greatest use of restrictive practices in segregated and congregated environments, it is necessary to clarify that restrictive practices are, and continue to be, used in non-segregated and non-congregate environments as well. Indeed, a 2020 US study of restrictive practices in schools clarified that students with disability are more likely to be restrained and secluded in both mainstream schools and segregated schools. However, the study further showed that while students with disability in mainstream schools are 'seven times more likely to be restrained and four times more likely to be secluded' than students without

disability, 'students in special education schools [segregated education] are almost guaranteed to receive a restraint or seclusion'.[283]

Research suggests that people with disability's lack of choice and autonomy within segregated and congregated settings is a distinguishing factor that contributes to the increased use of restrictive practices in these settings. An Australian study found that congregate environments, such as group homes, create unavoidable tensions in the environment whereby people with disability do not have a choice in who they live with, and may not get along with their enforced co-residents.[284] As articulated in a second Australian study concerning people with intellectual disability residing in disability residential services: '[r]estriction of rights was inherent in these services as a result of the physical, staffing and administrative environment …'.[285] This Australian study clarified that 'the physical environment and operational processes in [community-based] residential institutions … reflect an inherent contradiction' with the general principles outlined in Articles 12 and 19 of the CRPD.[286] The study determined that 'people who live in these services have not chosen to be there, and they have not chosen to have a service that is isolated from the community, is congregate and is physically outmoded',[287] and that 'the very nature of the buildings, and the ways they had been designed and used, restrict rights'.[288]

Arguably, explanations about the lack of choice and autonomy inherent to segregated and congregated settings in the community help to contextualise the findings of a UK study which followed the outcomes of 51 adults with intellectual disability who were said to have 'aggressive behaviours of concern'. These adults were moved from a long-term care facility into the community between 2004 and 2006. Upon leaving the long-term care facility, these adults were resettled into supported living accommodation, community residential homes or nursing homes in the community. The study, which focused on 'aggressive behaviours of concern', found a significant reduction in these perceived behaviours at both six months and one year following the resettlement of people into supported living accommodation. The study also found no differences in perceived behaviours for those adults with intellectual disability who were relocated to congregate residential or nursing home facilities in the community.[289] It is worth noting here that other studies have found that the congregate nature of residential or nursing home settings, and the consequential lack of private space for residents can 'result in invasive behaviours and a culture of abuse between residents'.[290] As explained in Chapter 3, perceived 'behaviours of concern' are best understood as communications of distress, resistance and protest to maladaptive, 'environments of concern' – in this case, the lack of choice and autonomy inherent to segregated and congregated settings.

Some researchers characterise the lasting and inherent contradictions and tensions present within community-based congregated and segregated residential settings such as group homes and nursing homes as stemming from 'passive institutionalisation'.[291] A 2021 analysis of 627 inspection reports into residential care for people with an intellectual disability in Ireland, for example, concluded that 'institutional care [is] being replicated in group homes in the community'.[292] Similarly, a rapid systematic review of design features that reduce the use of seclusion and restraint in mental health facilities stated that 'there is a tangible legacy between aspects of the design of the asylums and many of the subsequent inpatient units'.[293]

The systematic review noted that simply approaching inpatient units can be distressing for people with psychosocial disability because these units are often experienced as invalidating spaces where the 'testimony, personal capacity and competence' of the person with psychosocial disability may be doubted.[294]

The above findings are consistent with accounts presented in Chapter 2 of this report on Experiences of Restrictive Practices. In that chapter, we shared accounts by people with disability who described how their experiences of powerlessness in the context of restrictive practices was often humiliating and dehumanising. Many of those accounts focused on how these experiences of powerlessness, dehumanisation and humiliation were connected to the segregated, closed, isolating, cruel and punitive environments and settings that they and other people with disability are expected to endure. There were examples given in Chapter 2 of people with disability being stripped naked, strapped to a bed and left alone; being left in isolation without toilet facilities and having to urinate on themselves; having all options taken away through the experience of complete isolation through seclusion. However, as we noted in Chapter 3 on the Ecological System of Restrictive Practices, people with disability do not simply find themselves in these environments or settings, enduring this violence. Rather, people with disability are put in these environments, settings and scenarios by various workers and institutional staff members, often pursuant to law. For these reasons, as Chapter 3 detailed, many people with disability who are subject to restrictive practices speak of the power-dynamics of control that form between them and members of staff, and the power imbalance between staff and people with disability within institutional settings. We turn now to examine additional research findings on these institutional power-dynamics that are identified by people with disability. In section 4.5 of this chapter, we explore the legal dynamics enabling use of restrictive practices.

4.1.2 Institutional power-dynamics

Much of the literature on mental health settings, residential centres, group homes and residential aged care facilities identify an association between the nature of the environments (i.e., segregated, congregated, and closed environments) and the power-dynamics and modes of operation present within such environments. Indeed, there is a tendency within some of this literature to present and understand segregated, congregated, and closed environments such as mental health settings, residential centres, group homes and aged care facilities as 'total institutions'.[295]

The term, total institution, was put forward by sociologist Erving Goffman, and refers to 'a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life'.[296] Part of the significance of Goffman's recognition of total institutions is that it invites scholars to explore the power-dynamics between those who 'reside' and those who 'work' in such formally administered settings. Some scholars characterise this dynamic as 'power/control' relationships.[297] The Royal Commission into Institutional Responses to

Child Sexual Abuse drew heavily on Goffman's research, highlighting the impact of institutions upon internal cultures.[298] Australian research has noted that there is a tendency for staff in group homes to 'create a worksite rather than a 'home'' when there are more than three residents with disability living together.[299]

The concept of total institutions is also highly applicable to closed and congregate segregated residential settings where many people with disability live.[300] For example, a Swedish study showed that people with disability who reside in group homes are constantly faced with pressure to conform to, resist and/or negotiate the institutional structures and practices of power embedded in this form of residential environment. Part of the tension recognised in this study was that group homes are both homes for people with disability as well as workplaces for staff. As the study explained, there can be conflicting interests between the two. For example, group home residents may be fostered by staff to participate in a range of activities, but this fostering process may only occur according to the schedule of staff. The study further clarified that in the context of fostered participation of group home residents in the community, the activities residents were ultimately enabled to engage in were typically determined by staff, and according to what staff constituted as a 'normal' activity for a person with disability to participate in.[301] Staff further determined the 'ground rules' of the residents' participation.[302] Importantly, as a 2010 Australian report clarified, staff do not just determine the nature of activities people with disability in group homes have access to. Rather, as that report made clear:

> staff have access to residents' personal space, their body, and have the potential to control [and thus restrict] every aspect of their lives, including their sexuality, how and when they sleep, eat, wash, communicate, exercise, and rest.[303]

Notably, a study of the 'independent life' and 'independent living' of people with learning disabilities in group homes in Catalonia (Spain) explored several assumptions embedded in this context of power/control relationships. That study concluded that 'the idea that people with learning disabilities need help and protection appears to be taken for granted' in these settings.[304] The study clarified that as a result of this assumption, a 'care-based model' which 'reproduces the role of the person with learning disabilities as a 'person in care' instead of promoting their empowerment' continues to prevail under the guise of 'independent living'.[305] The study showed how this assumptions results in people with learning disabilities assuming they hold a secondary role to organisational staff in decision-making within the group home context.[306] Indeed, the study showed how people with learning disabilities in these settings perceive themselves as 'recipients of professional decisions and not as protagonists'.[307] Crucially, the study further showed that people with learning disabilities rarely questioned the role of support staff in decision making, in part because they did not view themselves as 'the subjects of rights but as an object of help' which required support because of their 'disadvantaged condition'.[308]

Findings such as those presented above have led scholars such as Niklas Altermark to argue that contemporary disability services work by control. In his book, *Citizenship Inclusion and Intellectual Disability*, Niklas Altermark explains how control present in disability services

is characterised by four key features. First, there is a system that monitors behaviour of people with disability. Second this system depends on a hierarchy between staff and residents. In this hierarchy, staff are always deemed capable of inferring what the resident is or is not allowed to do. Third, constant control is then facilitated through micromanagement by staff of mundane, everyday decisions, like when and what a person with disability will eat. Finally, this micromanagement and control is individualised such that the 'views and character of the individual support worker will impact how situations are handled'.[309]

Importantly, as several studies have shown, the constant control and micromanagement that occurs between staff and residents in segregated, congregated, and closed environments not only reinforces the hierarchy between the two, but is also both pervasive and subtle in its occurrence. A 2020 study of 627 inspection reports for residential care centres in Ireland, for example, found 4825 human rights violations. That study concluded:

> people with an intellectual disability were not regarded as citizens capable of inclusion in society. If they were, people would not have had to experience daily restrictions on their lives, be subjected to abuse and be segregated, isolated and neglected.[310]

Findings from this Irish study made clear that daily restrictions on the lives of people with intellectual disability living in residential care centres were often subtle in form, but had a significant impact on the life of the person, especially when these 'small limitations' or 'small issues' occurred daily, such as poor dining experiences. In a similar vein, a study of food choices in group homes in the USA showed that participants in group homes were aware of the numerous constraints and restrictions they faced as institutionalised people, including the constant surveillance that is built into the fabric of group home living. The study found that this constant surveillance 'contributes to increased institutionalization and poor health',[311] with group home residents fearful of repercussions if they were overseen or overheard by nearby staff to be critical of any restrictions in their choices of what to eat, or the lack of support they received in developing 'food skill'.

Finally, it is important to recognise that the concept of 'total institutions' was developed in the context of environments and settings that are 'cut off' from wider society. As such, this concept has primarily been used to draw attention to the power-dynamics inherent to these formally administer places of residence and work. Yet for people with disability, this power dynamic may extend beyond these 'cut off' settings too. Indeed, recent Australian-based research by Sally Robinson and colleagues makes clear that the power-dynamics between paid support staff and young people with disability is becoming increasingly mobile due to an increasing emphasis on movement away from clustering people with according to disability, and towards paid support workers facilitating 'community inclusion'.[312] However, as research from other contexts suggests, simply moving the relationship between support staff and people with disability out of institutional contexts and into the community does not diminish the possibilities for restrictive practices and other forms of violence to occur as part of the uneven power-dynamics of this pairing. For example, in a UK study of how women with disability handle abuse by personal assistance providers in the community, it was noted that:

> participants constantly reported weighing the pros and cons of a relationship that turned abusive, which is very similar to the way women without disabilities respond to abuse. Included in the equation are factors such as repeated difficulty finding and keeping quality PAS [personal assistance] providers, fear that the next provider might be worse, the lack of emergency back-up PAS, and the risk of being admitted to a nursing or foster home and/or losing custody of children because of not having an assistant.[313]

Similarly, studies of violence against women with disability typically recognise that this violence is often committed by 'caregivers', whether in the form of personal assistance providers, group home workers, adapted bus drivers or health care workers.[314] As a 2014 study explained, there is a power imbalance between these 'caregivers' and women with disability such that these women are often dependent on these 'caregivers' for most if not all aspects of their daily life. Consequently, both acquiescing to restrictive requests of these 'caregivers' (even if a woman knows the requests infringe her rights), as well as speaking out against these requests, holds significant consequences for the level of independence these women with disability may enjoy.

We note that there are minimal research studies on use of restrictive practices by family members and unpaid carers in private settings. This lack of research makes it difficult to assess the potential incidence of restrictive practice use in this context. However, family members have been identified as common perpetrators of abuse and violence towards people with disability more broadly.[315] More research is needed to explore the complex inter-dynamics of family, disability and violence.[316]

The above findings from the research literature provide indication of the institutional power-dynamics which take shape between support staff and people with disability. That is, dynamics where the home of a person with disability may be recast as a workplace, and the daily living activities of people with disability are kept to the schedule, imagination and inclinations of individual workers. Predominately, these findings about institutional power-dynamics help us to understand why segregated and congregated environments and settings have become places where people with disability are subject to the greatest use of restrictive practices. In the next section, we explore these institutional power-dynamics further, examining the nexus that appears to have formed between these power-dynamics and a range of 'workplace concerns' about safety.

4.2 Workplace concerns

In this section of the report, we outline four core workplace concerns that appear to work both separately and together to drive use of restrictive practices. First, we consider the experience levels of staff. Here we note that staff who have worked in their role for a long period of time are more likely to use restrictive practices against people with disability. These staff are often resistant to change, even after receiving contemporary training. As the research makes clear, part of the reason more established staff resist moving away from restrictive practices is due to concerns they hold about other complex workplace dynamics. In the second, third and fourth

parts of this section, we examine each of these dynamics in turn. Accordingly, in these sections of the chapter we bring attention to institutional cultures of blame and risk management; we attend to the occupational health and safety concerns of staff; and we engage with staff perceptions about their 'duty of care' obligations.

4.2.1 Staff experience levels and training

Evidence indicates the experience level of staff can drive use of restrictive practices. Research suggests that staff who have worked in their role for a long period of time are more likely to use restrictive practices against people with disability than staff who are less experienced in the role. To an extent this research finding is not intuitive. We might anticipate more senior staff to be aware of, and have made use of, a range of alternatives to restrictive practices. Part of the issue here appears to be that staff who have worked in their role for a long period of time may default to using restrictive practices. Indeed, a Canadian study of restrictive practices in group home settings found that 'care providers left to their own devices tended to use reactive, intrusive methods to handle [what they perceived to be] problem behaviour'.[317]

However, studies also suggest that staff who have worked in their role for a long period of time may also be resistant to change their approach. For instance, a Norwegian study into increased use of restrictive practices over the ten-year period following the introduction of legislation in Norway to reduce use of said practices, suggested restraint use increased in this context in part because highly experienced staff who had worked in their role for long periods of time may be 'less willing to change their practice'.[318] Similarly, it was hypothesised in a 2018 systematic review of the literature concerning staff training related to 'behaviours of concern' displayed by adults with intellectual disabilities in group home settings, that staff with significant experience of working with perceived 'behaviours of concern' may be resistant to adopting new, non-restraint approaches.[319] Thus, in essence, research suggests that staff with the greatest level of experience on the job may hold the belief that restrictive practices are necessary because 'this is how it's always been', with established staff experiencing frustration when this historically available practice becomes less readily available to them.[320]

It is necessary to clarify at this point that staff who are new to their role have also been found in some studies to rely on restrictive practices more than other staff members.[321] We can make sense of this seemingly contradictory finding in two ways. First, a review of literature concerning seclusion in mental health contexts found that some staff feel pressure from their colleagues in relation to how they handle seclusion.[322] The review showed that it was common for staff to not want to disagree with one another, especially if their team members had decided to move forward with a more controlling intervention than they were comfortable with using.[323] It is therefore plausible that new staff, who will be placed in teams with more experienced staff members, may feel pressure to rely on restrictive practices because of the approach their colleagues take. However, the research literature also suggests that new staff members are more likely to use restrictive practices in contexts where older, more experienced staff have left the workforce, and are therefore no longer of direct influence. Indeed, a recent review of

literature found that when more experienced staff leave the workforce and are replaced by less experienced workers, these workers may rely on restrictive practices when responding to scenarios that challenge their level of preparation and/or training.[324]

When considering findings such as those presented above, it may appear logical to address this driver through staff training. In theory, staff training could enable more experienced workers to update their perceptions about the apparent necessity for restrictive practices, while also providing the least experienced workers with a strong foundation for avoiding a reliance on restrictive practices moving forward. However, again, against intuition, the research literature does not support this conclusion. Indeed, it has been consistently found that increasing training and education of staff in relation to restrictive practices is associated with an *increased* use of restrictive practices. For example, a 2005 study concerning the treatment and management of perceived 'behaviours of concern' in congregate and non-congregate community-based supported accommodation in England and Wales found that 'use of physical restraint was associated more strongly with the proportion of staff who had been trained in physical restraint in the past years than with factors associated with [the perceived] behaviours of concern itself'.[325] Similarly, a 2018 USA longitudinal evaluation of an organisational change effort to minimise restrictive practices within a behavioural healthcare facility that serves people with intellectual, developmental and psychiatric disabilities who have been classified as 'high-risk' and 'at-risk', found that when staff are trained in 'behaviour medication and management' that focuses on the use of restrictive practices, these tactics are reported to happen frequently.[326] Finally, a 2018 systematic review of interventions for reducing restraint in individuals with intellectual disabilities and autism spectrum disorders found that short-term training can result in increases in use of restrictive practices.[327]

Explanations for this seemingly illogical outcome of staff training has not been fully explored in the research literature. Some studies suggest that increased use of restrictive practices post-training may occur because staff may have not 'acquired the skills taught in the workshop', may apply them 'incorrectly, indiscriminately or ineffectively', or may have instead learned that 'they should use restraints more often to prevent injuries'.[328] Other studies suggest that focusing staff attention on use of restrictive practices may have a reinforcing effect, even if the focus of the training is on reducing use of these practices and clarifying the limited contexts within which they are legally authorised to be used.[329] Finally, other studies return to the previously mentioned finding about staff resistance to change: that is, staff training may have few, if any, effect on staff who are committed to believing restrictive practices are necessary.[330]

Importantly, studies indicate that staff may be resistant to change in the face of training not just because of a preference to do things in the same way that they always have, or a belief that the old way of doing things is the best. Rather, staff may also be resistant to change because of a belief that the complex, workplace dynamics they currently negotiate would not support an alternative approach. For example, as a 2006 study of nursing staff in aged care found, '[t]he majority of participants could not realistically envisage a restraint-free environment could be possible, and felt this was too simplistic a notion for a complex problem'.[331] We turn now

to consider some of the complex, workplace dynamics that appear to inform some staff views about restrictive practices, and which in turn appear to drive the use of said practices.

4.2.2 Institutional cultures of blame and risk management

One of the workplace dynamics that appears to inform staff views about restrictive practices, driving their use, is an institutional or organisational culture of blame and risk management. For instance, a 2013 study into disability support workers in disability accommodation services in Victoria reported that workers felt a 'constant struggle' as they attempted to manage and negotiate a 'culture of blame and risk aversion perpetuated by institutional and professional actions of power'.[332] Similarly, a 2014 systematic review of literature concerning least restrictive practices in acute mental health wards determined that a 'blaming culture drives anxiety for staff and increases preoccupation with risk'.[333]

Crucially, some studies suggest that this institutional culture of blame and risk management is associated with the 'passive institutionalisation' previously described in section 4.1.1. Indeed, a 2017 study of risk management strategies utilised in psychiatric inpatient settings explained that 'the current framework of safety in mental health nursing is founded in persistent stigmatizing beliefs of individuals with mental illness and continues to uphold institutionalization-era practices of risk management that preclude the articulated aims of deinstitutionalized treatment'.[334]

One of the 'persistent stigmatising beliefs' that appears to uphold institutionalization-era practices of risk management and drive use of restrictive practices, is the belief some staff hold that people with disability are inherently risky and/or dangerous.[335] As Bernadette McSherry explains in a 2021 chapter, organisations in many societies operate form a risk management perspective which 'others' people with disability as 'risky'.[336] This othering, risk management perspective creates an '"us and them" perspective [which] can permeate mental health and aged care facilities, reinforcing the apparent intractable use of restraint'.[337]

In many organisational settings, this persistent stigmatizing belief typically centres around perceptions of so-called 'behaviours of concern'. As explained in Chapter 3, 'behaviours of concern' are best understood as both 'adaptive behaviours to maladaptive environments'[338], and as communications of distress, protest and resistance which occur in a historical context of vulnerability and dependency where others (i.e. service providers, teachers) have been empowered to interpret the behaviours of people with disability as 'dangerous, frightening, distressing or annoying'.[339] It is necessary to clarify that this understanding of 'behaviours of concern' is a relatively recent development. It replaces a traditional, stigmatising, pathologizing and incorrect belief that 'behaviours of concern' are somehow inherent to a person with disability and form part of their perceived impairments.

Despite this change in understanding about 'behaviours of concern', research suggests that staff who uphold traditional, risk-focused, stigmatising and pathologizing beliefs about people with disability are more likely to use restrictive practices. For instance, a 2017 New Zealand study of restrictive practices across different detention contexts – including prisons, health

and disability units, a youth justice residence, a children's care and protection residence, and police custody suites – found that across these settings, 'distressed behaviours were sometimes interpreted as aggressive ones, and responded to as such'.[340] This same study found that across these different detention contexts in New Zealand, '[t]here were indications of a high level of risk aversion in the units visited, resulting in staff safety taking too much precedence over patients' and prisoners' comfort and right'.[341] Notably, a 2021 scoping review of restrictive practices in adult secure mental health services proposed that '[a]s restrictive practices provide a method to contain/manage acutely unwell/risky service users these approaches may themselves become associated with feelings of safety and a reduction in feelings of anxiety or anger in staff.'[342] On this latter point, it is worth noting that a 2017 study found that mental health nurses who experienced anger in response to perceptions of 'personally valent aggression' from a person with disability (i.e., verbal aggression, humiliating aggressive behaviour, provocative aggressive behaviour, passive aggressive behaviour) were significantly more approving of use of restraint against the person with disability, although not seclusion.[343]

Given the influence an institutional culture of blame and risk management may have on staff use of restrictive practices, some research has considered the role strong leadership could play in addressing staff use of restrictive practices. For instance, a 2018 systematic review concluded that transparent workplace environments where the day-to-day demands of the job are perceived as manageable by staff would include, but not be limited to, a number of factors. These factors include:

> committed leadership and management, balance of power in the organizational hierarchy, clear directions from the organization's mission statement, congruent coaching from managers in order to know how to respond to CB ['behaviours of concern'], and good communication.[344]

Similarly, a 2014 study on the reduction and elimination of restrictive practices at the local, national, and international levels determined that 'unwavering leadership commitment and the appropriation of the necessary resources to make and support the change over time' were fundamental to change.[345] The 2014 study further posited that 'in every setting, regardless of location or population served, dedicated leaders are needed to embrace the ultimate goal: to strive to eliminate the use of R/S [restraint and seclusion] and treatment violence'.[346] Propositions such as these are supported by studies that suggest that unless explicit declarations against use of restrictive practices are made at the local, national, or international level, staff may continue to rely on restrictive practices in their work, and continue to assume that alternative methods of response are not possible.[347]

However, strong leadership alone would not be sufficient to address the institutional culture of blame and risk management which staff negotiate, and which drives use of restrictive practices. Rather, as a 2017 qualitative study of group homes in Victoria made clear, there are often two dovetailing forms of risk-management thinking informing use of restrictive practices by front-line staff.[348] There is on the one side, the institutional blaming culture described above – which has the potential to be at least partially addressed through strong leadership and declarations

against use of restrictive practices – but there are also staff concerns about their safety in their workplace. These additional fears about safety in the workplace need to be recognised as an additional driver for restrictive practices. We articulate and explore these fears separately next.

4.2.3 Occupational health and safety concerns

Australian research has identified a growing number of organisations which justify increased use of restrictive practices by reference to occupational health and safety concerns of staff.[349] For instance, a 2018 study of mental health nurses in Australia showed that mental health nurses often operate on the assumption that restrictive practices are necessary to maintain a safe environment.[350] Indeed, a 2020 Australian study of mental health nurses found that fear of experiencing occupational violence was a 'powerful catalyst' for use of restrictive practices in mental health settings.[351] Notably, participants in that 2020 study noted that 'lack of staff experience and expertise in recognizing early signs of escalation, and not being able to effectively de-escalate situations as contributing to staff feeling scared and fearful'.[352] Here we note the findings of a 2019 ethnographic study of psychiatric ward life that showed that 'the use of de-escalation methods were experienced differently by patients and staff, where for staff they were conceptualised as forming more humane methods to prevent the need for restrictive practices, whereas for patients, these practices were at times experienced as coercive ways for staff to gain compliance from the patient'.[353]

Crucially, it has been shown that mental health nurses were more likely to use restrictive practices in mental health settings in a situation where they felt 'let-down when they were exposed to violence and left to manage violent situations where the feeling was that the violence was reasonably foreseeable, and that proper plans and resources were not put in place'.[354] Similar findings about the connection between occupational health and safety concerns of staff and use of restrictive practices has been presented in the context of secure forensic settings,[355] group homes,[356] and schools.[357]

Of course, staff concerns about occupational health and safety do not occur in a vacuum. Rather, as outlined in section 4.1.2 above, these concerns both emerge from, and play out within, a context and ecological system where there are uneven power-dynamics between those who 'work' and those who 'reside' in these formally administered settings. These uneven power-dynamics set the scene for the occupational health and safety concerns of staff to trump the rights of people with disability in these settings. Indeed, studies remind us that to treat disability services as work sites for the purposes of occupational health and safety regulation overlooks the fact that these 'work sites' are also people's homes and community settings.[358] To this end, it has been proposed that disability service providers 'cannot be reasonably expected to exercise the same risk management' over a person's home or a community setting as they can over a conventional work site 'where they have primary responsibility and control'.[359] Additionally, and at the same time, other research suggests that there is a pervasive 'misrepresentation' of facts in many of these contexts, whereby it has become commonly assumed that the occupational health and safety concerns of staff are somehow 'mutually

exclusive' to the human rights realisation for people with disability.[360] This misrepresentation of facts results in the rights of people with disability being seen by some staff as 'secondary to taking an action that was perceived to increase staff safety'.[361] As discussed in Chapter 1, in reality, the rights of people with disability to freedom from torture, ill-treatment and violence are actually of high priority, as are their experiences and perceptions of use of restrictive practices.

Research suggests the misrepresentation of the relationship between the occupational health and safety concerns of staff and human rights realisation for people with disability is sustained by a number of systems beyond the immediate workplace environment. As a 2019 Australian study found, there is an uneven emphasis within disability policy between the rights of people with disability and the rights of workers.[362] As that study showed, while international and national policies often focus on the position and rights of people with disability, organisational policies were more likely to include acknowledgement of the rights of workers.[363] Moreover, as a 2021 study further explained, in the current Australian context, 'without careful co-regulator oversight [between the NDIS and Work Health and Safety regulatory schemes], the differences in sanctions, stakeholder participation, and effective enforcement models may skew actions in favour of workers and to the detriment of people with disabilities'.[364]

There is a final issue of note worth considering here: use of restrictive practices can in and of itself pose an occupational health and safety risk for staff. In the context of Australian mental health nurses, it has been found that use of restrictive practice is a source of 'considerable and ongoing occupational stress and distress' for staff.[365] Staff described how their perceived need to use restrictive practices in a context where they are scared about their safety left them feeling 'disappointed, distressed and even traumatised'.[366] Likewise, a 2017 study of risk management strategies utilised in psychiatric inpatient settings proposed that framing safety as 'the highest value' in mental health nursing was experienced as dehumanising and traumatising by people with disability, contributed to nurses' moral distress, and was ultimately ineffective in creating safer environments for people with disability and nurses.[367] Finally, a 2020 qualitative review of the literature found that counter to perceptions of safety, the use of restrictive practices in the context of mental health settings led to 'physical and psychosocial trauma' for both people with disability and staff, with nurses experiencing moral and ethical challenges in use of these practices.[368]

Comparable observations about the counterproductive consequences associated with using restrictive practices in response to occupational health and safety concerns of staff have been made in the context of disability care homes. Of note in this context, is the following extended account provided by social work scholar, Dr Chris Chapman, in relation to their experience of their previous work in using restrictive practices at a disability care home for Aboriginal children in Canada. Dr Chapman explains:

> At the treatment centre, it was routinely acknowledged that it was disturbing to physically restrain someone. This was spoken about as an 'unfortunate' aspect of the job […] But one of the things that came with 'helping' children who were 'this damaged', we said, was restraining and confining. The idea that there could be a world without restraints and locked

> confinement seemed clearly untrue, as evidenced by the children we worked with, and so some of us had to do the 'unfortunate' work involved in 'maintaining safety' for them and others. It's not that we didn't acknowledge that these restraints were traumatic for the children being restrained or for other children witnessing them, but we were the protagonists in the stories we told and believed. Our violence was only ever a response to their violence. The possibility of imagining their individual violence as a response to our structural, epistemic, and individual violence – both institutional/ableist and national/colonial/racist – was not available to us. […] We had nothing to do with their violence, until it erupted and our only role was to keep everyone safe. Even the room where children were locked up, which usually followed a physical restraint, was called a 'safe room,' which was clearly an act of manipulating perception – but it's hard to locate the agent of that manipulation. As staff, I think we all believed it. We perceived it. There was no safety without the safe room, we said, 'unfortunately'.[369]

There are at least three key insights to take away from Dr Chapman's reflections on the complex context within which use of restrictive practices and staff concerns about safety play out. First, following on from findings previously outlined about the occupational stress and moral distress associated with use of restrictive practices, Dr Chapman's account of their experience helps to articulate a 'no win' scenario in relation to use of restrictive practices. Restrictive practices are both violent responses to people with disability that are experienced as traumatising, *and,* even if framed organisationally as necessary and benevolent, responding to people with disability in this way is experienced as distressing and disturbing for many staff. Second, Dr Chapman's account begins to articulate a broader tension that may envelop and inform this 'no win' scenario. Here we are referring to the tendency of staff to focus on the immediate situation within which they are present (i.e., where an individual with disability is perceived to be making the environment unsafe), and not consider the broader, intersectional, and encompassing structural, epistemic, and individual factors that may have led to that situation forming in that moment. This is a complex tension with several elements, and we return to explore these elements in greater detail below, as well as in Chapter 6. For now, we note a final insight relevant to this section that can also be taken from Dr Chapman's experience, which is: the occupational health and safety concerns of staff appear to be intertwined with other concerns staff may also hold about the safety of others, and the duties staff feel they are obliged to carry out as part of their job (i.e., a duty of care). We attend to these additional workplace concerns separately below.

4.2.4 Perceived 'duty of care'

A duty of care is a legal obligation to avoid doing things that could foreseeably cause harm to another person. As suggested above, perceptions about the duty of care obligations staff hold towards people with disability often intertwine with staff concerns about their own occupational health and safety. This intertwining of concerns with perceived obligations appears to result in use of restrictive practices. For instance, a 2006 Australian study of an aged care facility that was transitioning to 'restraint-free care' found that one of the factors contributing to staff

resistance to this transition was a belief that restraint fulfilled part of their duty of care obligations to residents.[370] Staff believed that removal of restrictive practices would jeopardise their ability to maintain safety.[371] Importantly, the study found that the resistance of staff to move away from restrictive practices – in particular, use of environmental restraints such as bedrails – was 'not usually based on actual incidents of compromised resident safety, but reflected the anticipated preventive function of bedrails'.[372] Similar findings were presented in a 2008 study of physical restraint in residential aged care. This study found that staff often attributed use of physical restraint to a perceived duty of care to people with disability, and to legal issues. Indeed, 'duty of care issues' was found to be one of the major reasons for staff non-compliance with best practice, with fear of injury, staffing and resource issues, as well as a lack of knowledge regarding alternatives to restraint, also driving physical restraint in these settings.[373]

At the same time, it is important to recognise that the association between restrictive practices and staff concerns about perceived duty of care obligations can occur separately to staff concerns about workplace health and safety. Indeed, a UK study of disability support workers from a residential service for people with intellectual disabilities found that, among other things, disability support workers adopted 'interpretative repertoires about 'duty of care'' to justify their practices – which often involved 'granting or withholding choice, assuming responsibility for those in care and constructing service users as lacking capacity', as well as 'normalis[ing] limited choice in ways that undermined taking up more empowering practices'.[374]

In recent years, researchers have turned to consider in greater detail this tension between perceived duty of care obligations to people with disability and the rights of people with disability. This tension is often presented in the literature as a perceived struggle between duty of care obligations and the 'dignity of risk' of people with disability, in which the former typically overrides the latter.[375] As explained in Chapter 1, the idea of 'dignity of risk' has often been used by disability advocates to argue for forms of self-determination or choice within the context of substitute decision making and guardianship.[376] Article 12 CRPD mandates supported decision making, and simultaneously emphasises meaningful choice and equal protection from violence, abuse, neglect and exploitation. As Piers Gooding suggests, this implies a need for a shift away from a framing that is concerned with protection form risk, towards choice, information and equal protection from violence and abuse.[377]

In relation to the dignity of risk of people with disability in everyday disability services and supports, Altermark notes that:

> people without disabilities can smoke a lot of cigarettes, drink a lot of alcohol, be really overweight, get diabetes as a result, and numerous other things that disabled people are described as being prevented from doing. The difference is that non-disabled individuals are depicted as acting against their better judgement, whilst people with intellectual disabilities, in these situations, are described as being incapable of incorporating consequences into their deliberations on how to act.[378]

As a 2022 Israeli study of guardianship found, this diminished 'dignity of risk' feeds into use of restrictive practices, such that 'guardianship appointment was designed to prevent 'normal' and ordinary risks usually assumed by everyone', such as riding an electric bike, or buying cigarettes for friends.[379] Importantly, that study found that narrowing people with disability's capacity to engage in these 'ordinary' risks in this way had flow on effects. For instance, guardians were viewed by people with disability and service providers in the study as the 'responsible adult' who supervises all daily decisions.[380] The person with disability was consequently perceived as not being responsible for any of their actions.[381] We note the similarity between the finding of this Israeli study and the findings of the Spanish study of 'independent life' presented in section 4.1.2 above. As discussed in section 4.1.2, the latter study found that common 'case-based' assumptions embedded in institutional power-dynamics of control can result in people with disability no longer viewing themselves as 'the subjects of rights but as an object of help'.[382] While it is not possible to generalise the Israeli and Spanish contexts to that which operates in Australia, it is worth noting that an Australian study of people with intellectual disability residing in disability residential services found that staff working in these services often have 'very low expectations of the capacity of residents to make informed and safe decisions'.[383]

Notably, echoing the previous finding in section 4.2.3 about the 'no win' scenarios that workplace health and safety concerns produce, research into the association between restrictive practices and staff's perceived 'duty of care' to people with disability shows that these perceived obligations hold negative impacts for both people with disability and staff. For instance, a 2011 UK study considered how support workers managed the tension between protecting people with disability in a specialist group home from perceived risks, and promoting their independence and autonomy. The study focused on the support of people with Prader-Willi syndrome. The study found that organisational concerns about the perceived risk of people with Prader-Willi syndrome overeating, and the perceived 'duty of care' to manage this risk, were central to the structure of care delivery in the specialist group home, constraining the actions of both the people with Prader-Willi syndrome and workers. The study found that workers attempted to reconcile the tension between duty of care and recognition of residents' autonomy by either 'incorporating the promotion of independence into residents' care plans' or by 'deviating from standardised procedures to allow independence'.[384] These actions by staff led to questionable results, including residents being granted 'random and inconsistent moments of independence', and staff receiving reprisals for their deviating actions if discovered.[385] In the context of schools, it has been observed that while the 'safety' teachers and school authorities owe to students through a duty of care and to themselves through occupational health and safety laws at face value would seem to be of benefit to all students, 'children with disabilities are themselves positioned in the application of these laws as the site of risk and harm'.[386] Similar observations have been made in the context of people with dementia living in aged care settings, with scholars noting that when people with dementia are positioned as 'inherently risky', the duty to protect them from the harms associated with restrictive practices is overlooked or ignored.[387]

Crucially, as Scott Lamont and colleagues explained in their 2020 Australian study: duty of care is a 'source of obligation' that imposes responsibilities on those who bear it, but not powers. Specifically, healthcare professionals (and others in other contexts) are legally obliged to 'care

for patients according to the standards of their profession'.[388] As Lamont and colleagues clarify, part of the issue appears to be that health policy, organisations and staff confuse 'duty of care' obligations with the doctrine of necessity, which protects individuals from liability in situations of overwhelming urgency. This 'confusion' results in misguided and unlawful uses of 'duty of care' obligations as the legal justification for non-consensual coercive treatment. Importantly, other scholars point to the ways that 'the doctrine of necessity' also works as an enabler for restrictive practices.[389] Like Lamont and colleagues in relation to 'duty of care', these scholars note that there has been a systemic reliance on vague approximations of the doctrine of necessity to inform use of restrictive practices by medical, care and education workers.[390]

There are some obvious parallels between the rationales and actions taken by different workers who use restrictive practices in the name of 'duty of care' or the 'doctrine of necessity', and the actions of psychiatrists and doctors in hospital settings in what is characterised as 'defensive medicine' or 'defensive psychiatry'. 'Defensive' practices are practices or actions taken by physicians or psychiatrists that are primarily motivated by fear, including 'fear of patient dissatisfaction, fear of overlooking a severe diagnosis, fear of negative publicity'.[391] Studies show that these 'defensive' practices are commonly undertaken to avoid the potential for complaints, regulatory investigations and/or malpractice litigation arising from any of the formerly listed fears coming to fruition.[392] Previous experience of investigations resulting from negligence claims also act as a driver for some psychiatrists who engage in 'defensive' practices.[393] Notably studies show that these 'defensive' practices persist and are common even in countries that have a 'no-fault' malpractice and compensation scheme.[394]

'Defensive' practices have been shown to result in low-value care,[395] potentially undermine informed patient choices,[396] and occur in a context where the health and wellbeing of the person receiving this 'care' is no longer the sole or primary consideration.[397] In the context of psychiatry, it has been found that junior trainees – who may lack confidence and experience – have a higher propensity to engage in defensive practices, such as admitting people to hospital and placing them on higher levels of observation than necessary.[398] In the context of disability and mental health services more broadly, some scholars have suggested that misguided and unlawful enactments of 'duty of care' are defensive in behaviour, and arguably reflect a fear of being sued for negligence.[399]

The preceding pages of this chapter have identified four interlinking 'workplace concerns' that appear to drive use of restrictive practices. These pages described the resistance that experienced members of staff may have to moving away from restrictive practices due to the complex workplace dynamics they negotiate. These dynamics include working in an institutional culture characterised by blame and risk aversion; concerns about occupational health and safety in the workplace; and misguided attempts and 'defensive' stances towards duty of care obligations.

There is one final 'workplace concern' identified in the literature that we are yet to consider: the under-resourcing and understaffing of services and supports for people with disability. As will be demonstrated below, the under-resourcing of services and supports for people with disability not

only appears to envelop and contribute to each of the previously described workplace concerns described in this section, but also holds consequences for people with disability more broadly. For these reasons, we attend to this driver separately below.

4.3 Under-resourced services and supports for people with disability

In this section of the chapter, we consider the consequences of an under-resourced and understaffed disability sector. First, we attend to the ways that this sector drives restrictive practices. Here we clarify that there is a relationship between the resourcing of the workplace, staff perceptions of safety, and staff attitudes towards, and use of, restrictive practices for the purposes of maintaining a 'safe' environment. In the second part of this section we then consider some of the broader consequences an under-resourced and understaffed disability sector hold for people with disability, beyond use of restrictive practices. Before attending to these issues, it is important to clarify that the development of an under-resourced and understaffed disability sector cannot simply be reduced to an issue of funding, or the lack thereof. Many disability and aged care services operate for profit, or are wealthy charities. These services are therefore likely to be capable of spending more on staff and resources within the scope of their current available funding, but seemingly chose not to for financial reasons. We discuss this potential economic consideration in further below.

4.3.1 Under-resourcing and use of restrictive practices in services

In reviewing the literature concerning use of restrictive practices, it is apparent that the workplace concerns identified across section 4.2 of this chapter may drive use of restrictive practices. However, as we now explain, these perceptions and concerns are in turn driven by structural and economic issues within organisations and 'care' sectors. Specifically, perceptions about risks, safety and duty of care appear to be tempered by the resourcing and staffing of services and supports for people with disability. For instance, a 2019 review of healthcare staff on acute medical and frailty wards found that '[t]he reasons why restraints are used, whilst stemming from maintaining patient safety, are often due to low staffing levels and the inability to constantly watch at-risk patients due to a large workload'.[400] As other studies make clear, this relationship between resourcing of the workplace, staff perceptions of safety, and staff attitudes towards and use of restrictive practices for the purposes of maintaining a 'safe' environment, also contributes to staff reluctance to move away from using restrictive practices. Thus, for example, a 2018 study of mental health nurses found that these nurses believed that restrictive practices were necessary to maintain safe environments. Underlying these beliefs about necessity, were concerns about resourcing. The nurses 'did not feel confident that they had sufficient support, resources, environment, nor adequately prepared work-force to maintain safety should seclusion and restraint be completely eliminated'.[401] Similarly, a 2014 study of restrictive practices in psychiatric contexts found that psychiatric health care workers felt it

would be impossible to eliminate restrictive practices while key resourcing issues remained. Key resourcing issues identified included: 'staff shortages', a 'lack of education and time', and staff 'receiving low pay and not having the resources to do a good job'.[402] Indeed, studies have shown that in both adult mental health settings,[403] and old age mental health settings,[404] staff will override the moral and ethical challenges and physical and psychological trauma they feel (described in section 4.2.3 of this chapter) when using restrictive practices against people with disability, if they are resigned to the belief that without sufficient resources such as staffing, training and education about effective alternatives, there is no other choice but to use restrictive practices.

Understaffing is a longstanding, major problem in many institutional settings in Australia's disability sector and in Australian disability services more generally. A 2010 report detailed that:

> [t]here are typically vacant positions, high levels of sick leave, rapid staff turnover [in the Australian disability sector]. This means that staff typically work long hours and sometimes consecutive shifts which increases the risk of fatigue, stress and the potential for abusive practices.[405]

Likewise, the 2012 Senate Committee inquiry into *Care and Management of Younger and Older Australians Living with Dementia and Behavioural and Psychiatric Symptoms of Dementia* found that restraints are often overused in aged care settings to compensate for inadequate staffing, training and poor programming.[406]

In theory, the expansion in funds for support available through the NDIS should have improved available resourcing for individuals to meet basic needs and enable equal social and economic participation. However, a 2021 Australian study of safety-related attitudes and practices of 2,341 frontline staff working in disability services under the NDIS reflected that workers recognise 'deep inequalities pervading their organisations'.[407] The study explained that these deep inequalities recognised by staff lead to the unsafe, abusive, violent and neglectful experiences of people with disability being overlooked or dismissed by staff and management.[408] This same 2021 study found that safety concerns that workers may hold in relation to people with disability were 'subordinate to organisations' financial and resourcing decisions'.[409] This latter finding is worth considering further separately below.

A key part of the ecological system of restrictive practices identified by people with disability in Chapter 3 was workplace convenience. As outlined in section 3.3 of that chapter, when we listen to the accounts of people with disability who have experienced restrictive practices, we catch sight of an institutional culture where the efficient running and priorities of the workplace appear to influence staff decisions to use restrictive practices against people with disability. Indeed, when attending to the accounts of people with disability – as we did in that chapter – it becomes apparent that some people with disability experience restrictive practices and other restrictions on their freedom as a means by which staff at institutions can make their work easier, efficient, or simply, undisrupted. In turning now to consider the research literature on restrictive practices, it becomes clear that this element of workplace convenience identified through the accounts

of people with disability, is underpinned by, and inseparable from, the issue of understaffing and under-resourcing described in this chapter. Thus, for example, in the context of aged care, a 2006 study examining the barriers to overcoming restrictive practices found that restraint was 'considered the safest and most expedient option available'.[410] Likewise, the 2012 Senate Community Affairs References Committee's Inquiry *into Care and Management of Younger and Older Australians Living with Dementia and Behavioural and Psychiatric Symptoms of Dementia* determined that restraints in aged care were often used for the 'convenience and protection of the facility, rather than the clinical needs of the patient'.[411] A 2021 study further found that 'low-level' restraint – such as 'wedging a wheelchair under a table at mealtimes or placing a walker or care-bell out of reach' – was used by some staff to 'get the care work done'.[412] Finally, a 2020 Australian study of aged care recently observed that in this context, an institutional model of service delivery may be sustained by economic incentives for aged care service providers.[413]

Unfortunately, there have been few, if any, studies in Australia, or elsewhere, which have considered the association between use of restrictive practices and under-resourcing within other parts of the disability sector (i.e., beyond aged care). There have, however, been two studies of restrictive practices in the broader disability sector in the US which indicate that funding variables may contribute to use of restrictive practices as well. We consider these studies in greater detail below.

The first study, published in 2015, examined predictors of seclusion or restraint use within residential treatment centres for children and adolescents in the US. This study found that 'facility and funding variables accounted for approximately 27 per cent of the variance in the use of seclusion and restraint' in these treatment centres.[414] Consistent with the findings presented in section 4.1.1 above, the 'facility variables' identified in this study as driving use of restrictive practices included having more beds – that is, congregate environments – with these 'facility variables' identified as significantly increasing the likelihood of use of seclusion and restraint.

The second study, published in 2018, examined Medicare Home and Community-Based Services (HCBS) 1915(c) waivers and use of restraint in the US. HCBS waivers allow for people with disability in the US to receive services in community-based settings such as individual, family and group homes. This study found a relationship between the provision of mental and behavioural health services and the permittance of restrictive practices in these waivers. Specifically, states in the US that projected spending less per participant on behavioural health and crisis services produced more Medicare Home and Community-Based Services waivers that permitted restrictive practices.[415]

Further research is needed to establish if the organisational and state-based economic drivers for use of restrictive practices in the disability service context articulated in the US studies above translate to the disability sector in Australia. However, even if these two studies are set aside until their generalisability can be tested, the remaining research presented in this section suggests that the under-resourcing and under-staffing of services and supports for people with disability drives use of restrictive practices by creating sub-standard workplaces, where staff feel

unable to fully deliver the services and supports required for people with disability. Under these conditions, some staff may use restrictive practices as one of the only available and convenient ways by which they can manage the repercussions they experience from being required to work in an under-resourced and understaffed disability sector. Put differently, restrictive practices may act as one of the primary tools via which individual staff members can negotiate the broader structural and economic issue associated with an under-resourced and under-staffed disability sector. The following case study of 'Lena' provided in Interim Report of the Disability Royal Commission aptly illuminates these interrelated issues:

> When Lena arrived for her first shift as a disability support worker in a day centre, she expected it to be as advertised.
>
> 'On paper the roster of programs looked fantastic,' she told us. Participants, some with high needs, could choose different activities – for example, cooking, sewing, woodwork and drama. 'They should have been enjoying their life, but they weren't.'
>
> Instead she was confronted with 32 people, some restrained, some wearing face guard masks and some lying on the floor. There were only two staff and Lena was told to 'get on with it the best you can'.
>
> The restraints were 'the old fashioned chairs with belts on them ... and people that were ambulant ... would be strapped in'. The masks were forced on people to stop them spitting. Lena was shocked because 'the newer restraint laws would definitely have been in'.
>
> One man was lying on the floor eating chips. Lena was worried he might choke and tried to sit him up but was told, 'just leave him alone, there is nothing you can do'.
>
> The participants also had set bathroom times. One man had already used his bowels and Lena told her supervisor he needed to go to the toilet. The supervisor replied 'we can't take him now, it's not his time'.
>
> Lena's second shift wasn't much better and she put this down to the culture. The staff were old, institutionally trained or untrained; 'you don't even need a certificate anymore for casual staff'. Two shifts were enough.
>
> 'It was revolting,' she said.
>
> The next place she worked was run by the same company and she did one-on-one support. All the residents had complex behaviours including physical violence, compulsive eating and absconding. All doors, windows and the kitchen roller door were locked.
>
> The man Lena supported was a compulsive eater. Food soothed him, and he knew the staff kept their chocolates in the office. One day the supervisor found him there and yelled 'what the fuck are you doing' and told him to get out. When the man hesitated, the supervisor

grabbed him and physically removed him. Lena reported the supervisor to her manager but was told it wasn't her place to say anything. "I was casual and I didn't want to lose my job."

She supported the same man at a community centre during the day where the kitchen was open and lunch boxes were left out. With Lena's help he learned not to touch food that didn't belong to him.[416]

This longer account of Lena's experiences is important for two reasons. First, the account provides additional evidence in support of the contention raised in both this chapter, and in Chapter 3: that restrictive practices may become a convenience in settings that are under-resourced and under-staffed. As Lena's account specifies, in the first place she worked there were 32 people who required support, but only two staff to do the work.

Second, this account also provides indication of how the under-resourcing and under-staffing of disability supports and services underlies some of the other workplace concerns (beyond convenience) that have also been identified in this chapter. In particular, it should not be overlooked that Lena is a new member of staff who is seeking guidance from more experienced members of staff who support use of restrictive practices against people with disability, and who are stripping people with disability of dignity. When Lena tries to respond differently to a person with disability who she is worried will choke because of the scenario they have been left in, she is told to leave the person alone, that 'there is nothing you can do'. Similarly, when Lena tries to report the violence that her supervisor has perpetrated against another person with disability, she is told it is not her place to say anything. In other words, Lena's experiences suggest that some disability settings do not simply operate in a context where more experienced staff members may be resistant to change, or where newer staff members may feel compelled to go along with the choices more experienced staff members (as discussed in section 4.2.1 above). Rather, Lena's experiences further suggest that some disability settings also operate in a culture of silence, where speaking up and acting differently is actively discouraged.

Of course, it is important that we do not lose sight here of the repercussions this structural and economically-informed issue holds for people with disability. An under-resourced and under-staffed disability sector does not simply drive use of restrictive practices for some staff. Rather, there is potential for restrictive practices to be delivered by services that are intentionally keeping labour and resource costs low in order to enhance their profit or financial gain from service delivery. In other words, under-staffing and under-resourcing are arguably an avoidable economic decision which may have benefits for people other than service users and staff on the ground (e.g., shareholders, businessowners), this being particularly so in the disability and aged care contexts where many services are delivered by non-state entities including charities and businesses.[417] When restrictive practices are perceived and used by staff as a 'solution' to structural issues of under-staffing and under-resourcing that might actually be driven by maximising profit, financial gain and/or other forms of perceived 'efficiency', people with disability become subject to violent, dehumanising and traumatising practices, which ultimately strip them of dignity. More research is required to explore these economic dynamics of restrictive practices.

4.3.2 Under-resourcing, supports for parents and restrictive practices

The above section raised the issue of under-staffing and under-resourcing in 'care' sectors. It considered how these issues may inform use of restrictive practices in day-to-day service delivery. There are, however, other, broader consequences for people with disability of being provided with under-staffed and under-resourced sectors. Lack of supports and services for families with children with disability has been well documented for decades.[418] In the UK,[419] as well as elsewhere,[420] it has been found that families raising children with disability often report lacking day-to-day practical support, housing, care and other supports from professionals and governments. Parents also report a lack of community and social support and acceptance for parenting a disabled child, with one consequence being an increased need to rely on government supports and services.[421] There are also children with disability that may be in the care of the State. There is little to no research which considers the support, services and resource issues facing children in out-of-home-care.

In the Australian context, the lack of information, supports and services provided to families of children with disability has been recognised as one of the factors contributing to the forced sterilisation of children with disability in Australia.[422] While the exact nature of an association between an under-resourced and under-staffed disability sector and forced sterilisation of children with disability in Australia remains opaque, two studies conducted elsewhere are informative. First, a UK study of requests for sterilisation by parents of children with disability hypothesised that these requests 'may be driven by a combination of a fear of the risks associated with the person's transition to adulthood, parental contraceptive attitudes, the requirement for a permanent solution to potential pregnancy and concern about who would care for any grandchild'.[423] Second, an historical Icelandic study of sterilisation of six women with intellectual disability born between 1945 and 1965 noted that common to the narratives of these women were perceptions about limited choices and opportunities. For example, the women perceived a threat that their children would be taken away from them as a result of negative social attitudes towards women with intellectual disability having children.[424] These women were also concerned that their personal independence and ability to make autonomous decisions would be diminished if they chose to have children: they feared that this choice would increase their dependence on relatives, service providers and other staff members.[425] On this point, sterilisation as an apparent solution to the perceived burden on parents is also apparent in contemporary Australian court decisions on sterilisation.[426] Thus, these studies suggest that decisions about forced and consensual sterilisation of girls and women with disability appear to occur in a context where there are: (1) insufficient government services, housing and funded care arrangements to support these families in the absence of community support; and (2) socio-cultural barriers to parents of children with disability receiving sufficient support from their local community to assist in raising their child, in particular, disabling and ableist attitudes and beliefs held by the broader community. We explore some of these socio-cultural barriers further separately below.

4.4 Socio-cultural attitudes and norms

The social model of disability argued that disability is the outcome of social and political arrangements that systematically oppress individuals with particular 'impairments'. Recent theories of ableism further build on this position, arguing that norms about what it means to be human, or what constitutes an ideal human life, shape worldviews, practices and how people are treated. These norms create notions of superiority and inferiority. In this section of the chapter, we consider how socio-cultural attitudes and norms towards people with disability intersect with restrictive practices. We do this first in the context of ableism and disablism specifically, and then, in section 4.4.2, we consider the intersectional oppression people with disability experience more broadly.

4.4.1 Ableism and disablism

Ableism has been defined as:

> a set of beliefs, processes and practices that produce – based on abilities one exhibits or values – a particular understanding of oneself, one's body and one's relationship with others of humanity, other species and the environment, and includes how one is judged by others.[427]

It is proposed that 'ableism is the system from which forms of disablism, hetero/sexism and racism emanate'.[428] This is because this set of beliefs about favoured and preferred abilities 'leads to a labelling of real or perceived deviations from or lack of "essential" abilities as a diminished state of being'.[429] Thus, in the context of people with disability, ableism reflects 'species-typical normative abilities leading to the discrimination against them as "less able" and/or as "impaired" disabled people'.[430]

There are few, if any, studies that have directly explored ableism as a driver for restrictive practices. There are, however, broader findings within the research literature about ableism and the experiences of people with disability which are indicative of the ways that ableism encircles use of restrictive practices. Indeed, there are three key insights that can be taken from research literature about the overarching and encompassing role ableism plays in driving restrictive practices.

First, research literature tells us that ableism is often disguised in the service and support sector as benevolence; as a 'commitment to care', or well-intended 'protection' for people with disability. A review of literature concerning long-stay hospitals and community-based residences for people with intellectual disability, for example, emphasised the significance of service cultures and environments, including the role of staff attitudes, behaviour and boundaries, in promoting abuse of people with intellectual disability. The review indicated that these organisational variables are often ignored because of assumptions about organisational 'commitments to care' which may 'promote a desire to view current services as better and safer, and to rationalize abuse which does occur as the fault of undesirable individuals,

rather than considering organizational variables'.[431] The review noted a variety of common beliefs that sit behind abuse of people with intellectual disability in these organisational environments, including: 'a perception of people with intellectual disabilities as 'other' and of lower status, the belief that they do not understand what happens to them or what they suffer, that abuse is negated by their poor quality of life, the fault of the victim or is 'good' for them'.[432]

Similar views about people with disability as 'other' and 'lesser' have been documented in the school context. Indeed, Susan Baglieri and colleagues make the point that apparatuses such as IQ tests, segregated classrooms and schools, specialized psychologists, allied health and various service providers – although usually 'well intended' by those who promote them – are 'inherently ableist' because the intent of these services is to turn all children into the so-called 'normal child'.[433] As a 2020 study of gatekeeping and restrictive practices in Australian mainstream schools found, it is these kinds of attitudes and beliefs about people with disability that contribute to 37 per cent of families who participated in a national survey being told by educators, medical practitioners and allied professionals that 'segregation would be in the best interests of their child'.[434]

Crucially, these views about people with disability as 'other' and 'lesser', and the assumed subsequent need to 'protect' and 'care' for people with disability through segregation, restriction and intervention have been identified as a contributing factor to use of restrictive practices in several Australian research studies. Indeed, these ableist assumptions have been identified as playing a role in use of restrictive practices in group homes;[435] making of Supervised Treatment Orders against people with intellectual disability in Victoria (discussed further in section 4.5 below);[436] and making of guardianship orders in New South Wales (also discussed further in section 4.5 below).[437] Importantly, these views not only permeate professionals and staff using restrictive practices, but also judicial and tribunal members authorising use of restrictive practices. We return to the assumptions of the legal profession and judiciary later in section 4.5 when we discuss law as an enabler of restrictive practices.

Second, as the above literature suggests, there is an association between ableist assumptions and institutional settings which segregate and cluster people with disability. As stated above, people with disability may be placed in segregated environments which cluster people with disability together because of purportedly 'well intended' but still 'inherently ableist' beliefs. Indeed, as a reflective piece by a practitioner and academic within the disability services sector in Australia, Janice Maree Ollerton, makes clear, even day programs, which are socially expected to fulfil the 'well intended' aim of facilitating inclusion of people with disability, are ultimately characterised in their operation by their 'ableist segregation' which is, as Ollerton notes, 'largely unquestioned and tacitly accepted'.[438] As section 4.1.1 of this chapter detailed, the research literature is unequivocal: people with disability are subject to the greatest use of restrictive practices in segregated and congregated environments.

Lastly, the research literature indicates a connection between ableism and violence against people with disability in general. For instance, an analysis of literature surrounding issues of abuse and disability found that 'disabled people are vulnerable to disproportionate and

complex levels of abuse, and that this abuse is fostered by [disablist and ableist] assumptions prevalent in social attitudes'.[439] Similarly, in the context of children with disability, renowned disability scholars Dan Goodley and Katherine Runswick-Cole have argued that there is 'a propensity for violence against disabled children ingrained in the relationships, institutions and cultural acts of our time'.[440] Drawing on their empirical research with children with disability and their families, Goodley and Runswick-Cole explain that tied up within, and contributing to, this propensity for violence against children with disability is a culture 'in which disabled children and their families continue to be disavowed'.[441] Finally, writing in the context of women with disability in Australia, Didi and colleagues note that a lack of rights recognition, and rights being denied in social and economic life 'increase[s] the susceptibility of women with disabilities to greater forms of violence [including interpersonal violence and restrictive practices, among others] over longer periods of time, making it more difficult to escape the cycle of violence'.[442] The last two studies about violence against children with disability and women with disability remind us that people with disability are diverse, and may experience intersecting injustices and oppressions. We explore the connection between intersectional oppression and restrictive practices separately next.

4.4.2 People with disability and intersectional oppression

As was the case with ableism and disablism, there are few, if any, studies that explicitly explore the intersections of oppression as a driver of restrictive practices. Additionally, it is necessary to note that for some communities of people with disability, there are few, if any, studies about their experiences of restrictive practices in any regard. For instance, to the best of our knowledge, there are only a handful of studies that consider LGBTQIA+ people with disability and use of restrictive practices. To this end, a 2019 study, drew on the accounts of informal/family carers of adult people from LGBTQIA+ communities living with mental illness, or experiencing a mental health crisis, and not the accounts of the LGBTQIA+ adults themselves. That study found that 'mental health services created further trauma through restrictive practices such as compulsory treatment orders and forced injections'.[443] More recently, a 2022 book on *Queer and Trans Madness: Struggles for Social Justice* articulated the distress of queer and trans people subject to coercive mental health responses.[444] Finally, the National LGBTI Health Alliance explain the relevance of heterosexism to use of restrictive practices:

> Too often LGBTI older people are considered to be difficult clients and little time is spent by service providers to understand the background and needs of those clients. For LGBTI people in residential aged care, it is important that distress, for example, is investigated in context. It is reasonable to express distress at being discriminated against. It is reasonable to want to escape an environment where an older LGBTI person feels unsafe, or where they are denied access to their normal support structures.
>
> "I know a person who becomes agitated when their partner goes home after a visit. Because their relationship isn't seen as valid, they don't get proper comfort or reassurance from staff, and then their behavior is seen as difficult." – non-binary aged care worker, regional Victoria.

Decisions about the use of restraint may also be related to expectations of stereotyped behaviour. When older LGBTI people behave or present outside of those expectations, they may be seen as disruptive or troublesome.

"Many people including aged care services want women to be docile, compliant, quiet "sweet old ladies". That is also with regards to lesbians." Seventy-five-year-old lesbian, regional NSW.[445]

To the best of our knowledge, there has only been one study conducted in relation to restrictive practices and culturally and linguistically diverse people with disability. This study, published in 2016, provides a single case study of a refugee family in Australia whose son with intellectual disability was placed in a residential care service. The service ultimately applied for a guardian to be appointed, and restrictive practices were used against the young man with intellectual disability. The study determined that the family, whilst experiencing the economic and social pressures of resettlement, did not understand how to navigate the system or advocate on their own behalf.[446] There is a clear need for further research into the intersections of oppression and use of restrictive practices for people with disability.

There are, however, two overarching cohorts of people with disability for whom more attention has been paid to their experiences of restrictive practices. As such, there is some indication of how these cohorts experiences relate to other experiences of intersectional oppression. These cohorts are racialized populations with disability, including First Nations peoples with disability, and girls and women with disability. We outline the core findings in relation to these cohorts of people below.

In relation to racialized people with disability, research indicates that racialized people with disability are at greater risk of becoming subject to restrictive practices across all settings. For instance, a 2017 study of restrictive practices across different detention contexts in New Zealand, including prisons, health and disability units, a youth justice residence, a children's care and protection residence, and police custody suites found Mäori and other ethnic minority groups were overrepresented in seclusion and in prison segregation.[447] Similar results have been found in a US study of forensic psychiatric inpatient wards, with Asian and Black people more likely to be secluded than any other racial or ethnic group.[448] And, seclusion and prone restraint have been found to be more likely to be used on Black people with psychosocial disability in psychiatric inpatient settings in the UK,[449] with other studies indicating that Black people with psychosocial disability are more likely to be involuntarily detained in psychiatric inpatient settings.[450]

Notably, as a 2019 study concluded, it appears that in many cases, 'the most coercive aspects of services and most restrictive environments are typically disproportionately visited upon ethnic minority group members, especially young Black men in the United Kingdom and Aboriginal populations in North America and the antipodes'.[451] Indeed, studies have shown that young, racialized men with multiple disabilities, and especially young racialized men with autism, are most likely to be subjected to restrictive practices in disability and psychiatric services.[452]

Studies also show that young, racialized men with disability stay in residential treatment units longer than other people.[453]

Similar conclusions have been drawn in the context of schools. Indeed, several recent studies have found a disproportionate use of excessive force, restraint and punishment in school contexts which is 'skewed toward disabled children and disabled children of color in particular'.[454] As explained in a 2021 US study, 'racialized and ableist discourses mediated processes of surveillance, escalation, and physical restraint, leading educators to disproportionately position Black students, particularly boys and those with disabilities, as "behavior problems"'.[455] Findings such as these have led Australian scholars to invite us to consider how colonial patriarchy that may have once operated explicitly through segregation and institutionalisation of First Nations peoples may now operate in a more diffused and medicalised way on the basis of 'disability' and 'health'.[456] While such work is yet to be conducted in the Australian context, Canadian social worker and academic Dr Chris Chapman offers the following reflection from their time working in a residential treatment centre where restrictive practices were used against First Nations peoples with disability. They explain:

> The idea that we were eradicating the Indian in the child through our interventions would undoubtedly have been abhorrent to every single staff person I worked with. But the idea that we were eradicating oppositional defiance disorder, attention deficit disorder or attachment disorder through our institutional practices would have seemed great to most of us. So I would like to suggest that the erasure of any trace of colonialism was facilitated through the diagnoses that justified the children's intakes.[457]

The second cohort of people with disability for which more scholars have considered the relationship between intersecting oppression and restrictive practices is girls and women with disability. Notably, almost all literature that attends to intersecting oppression and restrictive practices in relation to girls and women with disability concerns interventions related to menstruation and reproduction, particularly forced sterilisation and menstrual suppression. The literature recognises that forced sterilisation predominately targets girls and women,[458] not boys and men, although men can be subject to anti-libidinal medication and vasectomy.[459]

In an Australian law and policy context, menstrual suppression is explicitly identified as a form of restrictive practice in the NDIS Quality and Safeguards Commission's *Regulated Restrictive Practices Guide* (*October 2020*). This guide states:

> The use of medication for menstrual suppression due to behaviours of concern for example, distress and hygiene (e.g. smearing) is a chemical restraint under the NDIS (Restrictive Practices and Behaviour Support) Rules 2018. The use of medication for menstrual management is not considered chemical restraint when:
>
> 1) it is prescribed for the treatment of a diagnosed medical condition (e.g., endometriosis); or
>
> 2) the person with disability has requested and consented to this treatment.

> It is important that women with disability are provided with information in a meaningful way to support their decision-making about their reproductive and sexual health. Informed consent needs to be documented and the person must also understand that they can withdraw consent at any time.
>
> Menstrual suppression should only be considered when other options have failed or if there are significant gynaecological or other medical reasons. Alternative strategies should be trialled to solve issues such as fear of blood, smearing, hygiene problems and/ or pain and distress.[460]

In 2020, the Victorian Senior Practitioner published a report on the factors associated with menstrual suppression use for females with a disability.[461] The report included analysis of information on all people (n=82) subject to menstrual suppression reported as chemical restraint on the Victorian Restrictive Intervention Data System (RIDS) between 1 July 2018 and 30 June 2019. The report reviewed the Behaviour Support Plans (BSPs) of a random selection of people (n=23) in the study. This review found that in some cases, no behaviour of concern was identified in the BSP. Instead use of menstrual suppression was reported for other reasons, 'such as choice, distress or contraception', or, for some, 'no information was provided for purpose.'[462] The report also found that all but two of the 82 people in the study subjected to menstrual suppression were subject to other restrictive practices. The majority (n=56) were 'reported as being subject to the use of other chemical restraints, both routine use and *pro re nata* (PRN)'.[463]

Anti-libidinal medication for males over the age of 18 years is also included in the NDIS Quality and Safeguards Commission's *Regulated Restrictive Practices Guide* (*October 2020*). Here it is stated that:

> Anti-libidinal medications reduce sexual arousal. When prescribed for people with disability to address problematic sexual behaviours, this is a chemical restraint. Anti-libidinal medication should only be considered for a small population of people who engage in sexual offending behaviour where other interventions alone have not worked, and where there is a high risk of further offending by the person.
>
> A person's risk of sexual offending behaviour should be determined by thorough assessments conducted by trained practitioners, using current evidence-based risk assessment tools, self-reports and a functional behaviour assessment. Anti-libidinal medications must not be used in males under the age of 18 years, or in other instances where bone and testicular development is not yet complete.
>
> Anti-libidinal medication should not be used on its own to manage problematic sexual behaviour. Instead, it should be one part of treatment in addition to behaviour support strategies and psychological therapy. Due to the complex nature of these behaviours, a collaborative approach is needed to provide the best support and to work towards less restrictive practices. Anti-libidinal medications have significant physical side effects and require ongoing close medical monitoring and regular review.[464]

It is interesting to note that the circumstances in which anti-libidinal medication can be used against males over the age of 18 years as a regulated restrictive practice is much narrower than use of menstrual suppression against girls and women. As previously stated, the literature also recognises that although men can be subject to anti-libidinal medication and vasectomy, forced sterilisation predominately targets girls and women. For this reason, some scholars have characterised forced sterilisation as an example of the power of medicine over women, recognising that this plays out in intersectional ways. Indeed, Sifiris concludes that power and discrimination can 'combine to the detriment of women who are marginalised for reasons other than gender', such that, 'the involuntary sterilisation of women with disabilities is in part a manifestation of the systemic discrimination that people with disabilities suffer in many aspects of life and of the control which society at large and the medical profession specifically exercises over the lives of people with disabilities'.[465] To this end, a 2014 study of Australian doctors' views of sterilisation of men and women with intellectual disability found that doctors did not view sexual freedom as being as desirable for adults with intellectual disability compared with other adults in the population.[466] The study further found that doctors endorse sterilisation when the person with intellectual disability is:

> considered unable to parent, or when the available parenting support is limited or costly to society, as well as health issues, including when there is a risk that the disability could be passed on to a child or when parenting or pregnancy presents a significant psychological or physical health risk to the individual with ID.[467]

We note here the potential synergy between this finding about why doctors endorse sterilisation of people with intellectual disability and the findings observed in section 4.3.2 above about forced and consensual sterilisation of girls and women with disability appearing to occur in a context where there are: (1) insufficient government services, housing and funded care arrangements to support these families in the absence of community support; and (2) socio-cultural barriers to parents of children with disability receiving sufficient support from their local community to assist in raising their child, in particular, disabling and ableist attitudes and beliefs held by the broader community.

Crucially, other studies have noted that in the context of forced sterilisation, 'diagnostic overshadowing' may play a role. Here it is proposed that medical practitioners may be limited in their ability to explore solutions beyond clinical frameworks. In the context of forced sterilisation, this limitation of medical practitioners may mean that 'behavioural symptoms displayed by intellectually disabled people are attributed to impairment effects rather than social difficulties'.[468]

It has been argued by reference to analysis of the Australian legal doctrine on sterilisation, that social norms of ability, gender and sexuality intersect in relation to the legal permissibility of forced sterilisation of girls with intellectual disability.[469] As explained by Linda Steele:

> While it is acknowledged that all children require care and assistance, the level necessarily provided to girls with intellectual disability is viewed as exceeding that typically provided to children without intellectual disability. Moreover, girls with intellectual disability are often

> viewed as overly sexual and visceral (for example, playing with menstrual blood and used sanitary pads, vulnerable to sexual assault, sexually promiscuous, overly friendly with strangers, menstruating early, unable to regulate toileting) such that their bodies are hyper-permeable compared to children without disability. In relation to their inability to give consent, while all children have reduced decision making abilities as compared to 'normal' adults, children without intellectual disability are assumed to be constantly developing towards full adult levels of capacity, whereas children with intellectual disability (who are typically referred to in age equivalents and infantilised as eternal children) are effectively 'frozen in time' as 'children' and deviate from age-related norms of decision making ability. In this respect, girls with intellectual disability deviate from age-specific norms of ability, gender and sexuality.[470]

As Steele explains, these perceived deviations work to position girls with disability as 'abnormal' such that 'the violence of sterilisation of girls with intellectual disability is beyond legal comparison to forms of violence against children without disability, and hence cannot be comprehended as a discriminatory practice against girls with intellectual disability'.[471] We turn now to consider separately and in detail the legality of restrictive practices, and what it means for some people with disability to experience violence that is beyond legal comparison and thus cannot be comprehended as a discriminatory practice.

4.5 Law as an enabler of restrictive practices

As discussed in Chapter 3, some people with disability perceive there are no consequences for those who use restrictive practices. In other words, some people with disability are of the view that those who carry out restrictive practices do so with impunity. As explained in that chapter and elsewhere in the report (Introduction, Chapter 1), currently, depending on context, restrictive practices are permitted by law. This means that it is legally permissible at this time for a person with disability to be subject to coercive and non-consensual interventions – such as those described in Chapters 2 and 3 – so long as those interventions adhere to the legislative and regulatory frameworks surrounding authorisation and use of restrictive practices. As such, in this report, we regard law as a core *enabler* of restrictive practices. As we shall discuss, however, there are multiple legal pathways for the authorisation of restrictive practices, which differ depending on jurisdiction, service context and 'consent' of the person. Indeed, one issue with the current regulation and authorisation regime is that while law enables use of restrictive practices, the source of this authorisation will vary based on context, thus resulting in a complex and inconsistent system.

This section discusses law as an enabler of restrictive practices across three parts. It begins in section 4.5.1 by introducing the concept of 'disability-specific lawful violence' as a conceptual frame for understanding the connection between violence and the role of law as an enabler of restrictive practices. In section 4.5.2, we then outline multiple legal pathways to authorising use of restrictive practices, including guardianship, the Family Court welfare jurisdiction, disability and mental health legislation, and the *parens patriae* jurisdiction of the Supreme

Court. Here we engage with scholarly commentary and critique on these legal pathways, noting the common social norms and cultural assumptions about disability that mask or justify the harm perpetrated against people with disability. Finally, in section 4.5.3, we consider some of the broader consequences for people with disability of law's enabling role in use of restrictive practices. These consequences include the absence of liability and redress for the harm caused to people with disability.

A preliminary note is required here. In previous sections of this chapter, we have engaged heavily with scholarly texts. While scholarly literature is still used in the pages that follow, the primary data source for this section of the report is legislation, court judgments and tribunal decisions. We turn to this different set of empirical data because this set of data provides direct insight into how legal doctrine, judges and the legal profession shape the parameters for use of restrictive practices.

4.5.1 Disability-specific lawful violence

Restrictive practices are coercive and non-consensual measures. As Chapters 2 and 3 detailed, those subject to restrictive practices describe them as painful, traumatic, fear-inducing and punitive. Typically, circumstances giving rise to the coercive and non-consensual measures described in Chapters 2 and 3 would fit within criminal and civil legal definitions of assault or false imprisonment. However, use of restrictive practices does not routinely give rise to criminal charges and civil litigation. This is because, in most cases, restrictive practices are granted formal authorisation by law.

The starting point for understanding the legality of restrictive practices can be found in the relationship between bodily inviolability and consent. This was articulated well by Mason CJ, Dawson, Toohey and Gaudron JJ in the Australian High Court decision of *Marion's Case* (incidentally, a High Court decision on sterilisation of girls with intellectual disability).
In *Marion's Case*, the judges state:

> […] the law treats as unlawful, both criminally and civilly, conduct which constitutes an assault on or a trespass to the person. […]
>
> The corollary of these provisions, which embody the notion that, prima facie, any physical contact or threat of it is unlawful, is a right in each person to bodily integrity. That is to say, the right in an individual to choose what occurs with respect to his or her own person.
> In his Commentaries, Blackstone wrote 17th ed. (1830), vol 3, p 120:
>
> > "(T)he law cannot draw the line between different degrees of violence, and therefore totally prohibits the first and lowest stage of it; every man's person being sacred, and no other having a right to meddle with it, in any the slightest manner".

> Consent ordinarily has the effect of transforming what would otherwise be unlawful into accepted, and therefore acceptable, contact. Consensual contact does not, ordinarily, amount to assault. However, there are exceptions to the requirement for, and the neutralising effect of, consent and therefore qualifications to the very broadly stated principle of bodily inviolability. In some instances, consent is insufficient to make application of force to another person lawful and sometimes consent is not needed to make force lawful.[472]

It is therefore a fundamental legal principle that individuals should have their bodily inviolability and autonomy over their bodies respected. It is through giving or withholding of consent that individuals control what happens to their bodies. Criminal and civil laws on assault reflect this fundamental legal principle through punishing someone who makes contact with an individual's body without that individual's consent.

However, this fundamental legal principle does not apply in the same way to everyone. Criminal and civil laws on assault and false imprisonment provide for various exceptions to the general rules about the illegality of non-consensual contact and deprivation of liberty. One such exception is that the fundamental legal principle does not apply to individuals who are deemed as lacking capacity to consent – by reason of young age, or cognitive and psychosocial disability – in such a way as to recognise their autonomy over their bodies.

Given the role of law in authorising use of violence in exceptional circumstances against some people with disability, Steele has proposed the concept 'disability-specific lawful violence' to describe these practices.[473] While this concept was originally developed in the context of Family Court authorisation of sterilisation of girls with intellectual disability, it has since been broadened to be applied to other contexts where restrictive practices are authorised or used, including through guardianship orders and the operation of disability services more broadly.[474] As discussed below, the 2015 Senate Standing Committee on Community Affairs report on *Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability* (hereafter, Senate Standing Committee Inquiry) built on this conceptualisation as a useful way to describe the use of restrictive practices against people with disability.[475]

The concept of 'disability-specific lawful violence' can be used to make sense of the ways that restrictive practices act as a form of violence that occurs irrespective and even because of their legal permissibility. Disability-specific lawful violence refers to coercive and non-consensual interventions in the bodies and lives of people with disability that are permitted by law specifically on the basis of disability (or characteristics associated with disability, such as 'mental incapacity'), and by reason of this, are rendered beyond legal accountability and redress.

In applying this concept to restrictive practices, scholars typically recognise that understandings of what constitutes violence are often informed by how violence is defined and prohibited through law. In particular, criminal legal offences of assault and enforcement of these laws

through criminal justice systems inform popular understandings of violence. As stated above, authorised restrictive practices sit outside these criminal and legal definitions of assault and false imprisonment. This distinction means that restrictive practices might not be understood within the justice system or within society more broadly as violence. This tension, and the consequences it holds for recognising restrictive practices as forms of violence, was considered in some depth in the Senate Standing Committee Inquiry.

In Chapter 4 of its inquiry report, the Senate Standing Committee devoted a section to disability-specific lawful violence. The Committee defined disability-specific lawful violence as 'therapeutic interventions which would be deemed assault in any other context'.[476] The Senate Standing Committee elaborated as follows:

> The terms of reference for this inquiry provides the following definition of violence: 'violence, abuse and neglect' is broadly understood to include, but is not limited to: domestic, family and interpersonal violence; physical and sexual violence and abuse; psychological or emotional harm and abuse; constraints and restrictive practices; forced treatments and interventions; humiliation and harassment; financial abuse; violations of privacy; systemic abuse; physical and emotional neglect; passive neglect; and wilful deprivation.
>
> What this definition does not explicitly state, and which has been made clear through evidence to the inquiry, is that many of these forms of violence are considered by the health, legal and disability service sectors to be lawful therapeutic practice:
>
> > Many of the practices would be considered crimes if committed against people without disability, or outside of institutional and residential settings. However, when "perpetrated against persons with disabilities", restrictive practices "remain invisible or are being justified" as legitimate treatment, behaviour modification or management instead of recognised as "torture or other cruel, inhuman or degrading treatment or punishment".[477]

Importantly, as the Senate Standing Committee's discussion of disability-specific lawful violence suggests, disability-specific lawful violence does not only take shape through issues of legality. Rather, there are also cultural assumptions about disability which can mask or justify the violence being perpetrated against people with disability as 'therapeutic'. Shane Clifton, in his report for the Disability Royal Commission into hierarchies of power elaborated on some of the cultural assumptions that underpin lawful violence against people with disability. Clifton explained:

> Paternalism in healthcare is at its most dangerous in non-consensual medical interventions. Sometimes labelled by critics as 'lawful medical violence', non-consensual interventions are justified as care because of the medicalisation and pathologisation of disabled bodies, behaviour, and life circumstances. Women with disability are especially vulnerable to lawful medical violence, such as when they are subject to deprivation of sexual liberty, forced contraception, and forced sterilisation, rendering them effectively genderless and sexless, less than human.[478]

Therese Sands and Rosemary Kayess, in their research report for the Disability Royal Commission concerning the convention on the rights of persons with disabilities also drew attention to the intersections of law and socio-cultural norms. Sands and Kayess explained:

> Articles 12, 14, 15, 16 and 17 provide the key human rights standards to expose violence, abuse, neglect and exploitation, and, in their most egregious form, torture and ill-treatment within the law, policy and practice frameworks of care, treatment and protection. Underpinned by ableism, these law, policy and practice frameworks have hidden individual, systemic and legal forms of violence, abuse, neglect and exploitation. This has meant that these experiences are sanitised, normalised and legitimised within the language of care, treatment and protection.
>
> Reforms of these frameworks have often not questioned the legitimacy of practices that, for example, allow for substitute decision-making; the application of behaviour management practices, such as restrictive practices; the involuntary detention and treatment of people with disability; the placement of people with disability in institutional settings, including groups homes; and medical interventions performed for the 'best interests' of the person without their personal consent. Many of these practices constitute legal violence, in that they can be applied lawfully to people with disability with no recourse or redress.[479]

We turn now to consider some of the pathways to legal authorisation of restrictive practices in Australian law. In so doing, we draw attention to the cultural assumptions about disability that enable these pathways to be held in distinction to criminal and civil laws of assault and false imprisonment.

4.5.2 Multiple legal pathways to enabling restrictive practices

There are multiple legal pathways to authorisation of restrictive practices. As indicated above, while it is clear that law has a role in enabling use of restrictive practices, the exact source of authorisation will depend upon jurisdiction, service context and, to an extent, the person themselves (for example whether they are a child or an adult). These multiple pathways to legally authorise use of restrictive practices might include guardianship legislation, disability legislation, the Family Court's welfare jurisdiction and the Supreme Court's *parens patriae* jurisdiction. An overview of each of these pathways to restrictive practices authorisation are discussed in this section of the chapter. Before we outline these pathways, however, four points of clarification are required.

First, we note that there are other legal pathways that enable restrictive practices not discussed in this section of the chapter. These other legal pathways include forensic mental health legislation, mental health legislation, and child protection legislation, among others. These pathways have been considered in significant depth in several recent inquiries, including the *Royal Commission into Victoria's Mental Health System, the Parliamentary Inquiry into the Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia*, the

South Australian *Royal Commission into Child Protection Systems*, the *Royal Commission into Institutional Responses to Child Sexual Abuse,* and the *Royal Commission into the Protection and Detention of Children in the Northern Territory.*

Second, we note that while Commonwealth NDIS and aged care legislation regulates use of restrictive practices in the context of funded service provision, this legislation is not necessarily the source of authorisation for use of restrictive practices. Commonwealth NDIS legislation, for example, while laying out the types of practices that are authorised and regulated, defers to State or Territory legislation for authorisation itself (where it is applicable) and thus authorisation is in effect shared between jurisdictions.[480] Further, in some State or Territory legislation or policy, use of restrictive practices may require consent of the person, a parent or a guardian.[481] In the latter case, authorisation for use of restrictive is thus also shared with guardianship legislation. This distinction occurs because substitute consent to use of restrictive practices through other legal regimes (i.e., those specified above and detailed below) is generally still required to ensure the intervention is consensual vis-à-vis the individual restrained and the individual restraining. That said, while other legislation is important, regulatory regimes structured around authorised and unauthorised restrictive practices in the NDIS and aged care legislation are a significant dynamic in contemporary use of restrictive practices because they are conventionally understood as facilitating reduction of restrictive practices. We return to examine this conventional understanding in detail in Section 5.3 of this report, when we consider current approaches to reduction and/or elimination of restrictive practices.

Third, it is important to emphasise the variations that occur between different legal pathways to authorising restrictive practices. There is, for instance, variation in the availability of some legal pathways to authorise restrictive practices. For example, restrictive practices for adults can be authorised through guardianship legislation; below we will explore guardianship legislation in New South Wales and Western Australia. In other contexts, authorisation can occur through disability service legislation which includes provisions specifically on authorisation of restrictive practices, such as the *Disability Act 2006* (Vic). The extent of use of different legal pathways also varies between jurisdictions. For example, as we discuss below, most publicly available judgments relating to the Supreme Court's *parens patriae* jurisdiction come from New South Wales, as compared to in other state and territory jurisdictions. Some legal pathways also only apply to particular populations, or are often used in relation to particular restrictive practices. For instance, the Family Court welfare jurisdiction applies only to children, and has been utilised particularly in relation to sterilisation. Likewise, the *parens patriae* jurisdiction in New South Wales is primarily used in relation to children in out-of-home care.

Finally, we note that gathering an evidence base on the full extent of the use of any of the legal pathways to restrictive practices we consider below is hampered by the absence of a comprehensive, publicly available dataset of judgments. There is also a lack of basic statistical information on judicial decision-making in circumstances where judgments are not possible because it is important to preserve confidentiality of individuals subject of these decisions. These gaps in data availability limit the ability of this report to fully articulate the enabling role that law plays in relation to restrictive practices.

4.5.2.1 Guardianship legislation

Restrictive practices on adults can be authorised through Australian state and territory guardianship legislation. Here we focus on guardianship provisions in two jurisdictions as case studies: New South Wales and Western Australia. We note the Disability Royal Commission has commissioned a separate report on guardianship which will likely consider all Australian jurisdictions. There are also academic commentaries on guardianship law across Australia.[482]

In the below overview of New South Wales and Western Australian guardianship law, we draw attention to three key points of commonality relating to the legal authorisation of restrictive practices. First, in some jurisdictions, restrictive practices can be enabled through appointment of guardians. Second, in some jurisdictions, and certainly in New South Wales and Western Australia, guardianship law has an emphasis on the 'best interests' of the person with disability; guardianship also emphasises community inclusion and protection from harm. Third, in some jurisdictions, including New South Wales and Western Australia, guardianship authorisation is required (or is assumed by NDIS providers to be required) for use of restrictive practices in NDIS services in order to comply with regulatory requirements.

New South Wales

In New South Wales, under the *Guardianship Act 1987* (NSW), a guardian can be appointed when the New South Wales Civil and Administrative Tribunal (NCAT) is satisfied the person is a 'person in need of a guardian'.[483] A 'person in need of a guardian' is defined as 'a person who, because of a disability, is totally or partially incapable of managing his or her person'.[484] Before a guardian can be appointed, the NCAT must take into account the views of the person.[485] NCAT must also give consideration to preserving family relationships and cultural and linguistic environments.[486]

Once appointed, a guardian takes on a substitute decision-making role for the person with disability. The guardian 'has the power, to the exclusion of any other person, to make the decisions, take the actions and give the consents (in relation to the functions specified in the order) that could be made, taken or given by the person under guardianship if he or she had the requisite legal capacity'.[487] The types of decisions a guardian is empowered to make is outlined in a guardianship order.

Guardianship orders can be plenary (i.e., covering all aspects of an individual's life) or limited (i.e., covering specific aspects or 'functions'). The nature of guardian functions was explained by the Guardianship Division of the NCAT in *GZK*:

> The functions of guardianship are not defined by legislation. Rather, over the years since the commencement of the Act, the Tribunal (and its predecessor, the Guardianship Tribunal) has issued orders appointing guardians with specific functions to make substitute decisions in certain domains of the person's life. These functions stem from the foundational parens

> patriae jurisdiction, which originally gave plenary authority, and have been appropriately adapted for modern needs. For example, decisions about where the person should live (the accommodation function), decisions about what services they should receive (the services function), and decisions about what health care they should receive (the health care function), to name but a few.[488]

In addition to the functions listed by the NCAT in *GZK,* guardians can be empowered to make decisions specifically in relation to restrictive practices – through the 'restrictive practices function'. This function of guardianship was further explained by the Tribunal in *GZK*:

> Currently in NSW, the "restrictive practices function" that is issued by the Tribunal, as outlined in detail in HZC, allows an appointed guardian to give or withhold consent to a range of restrictive practices, such as physical restraint, chemical restraint, environmental restraint or seclusion, to assist in the management of behaviours of concern exhibited by a person with disability. The implementation of these practices is significantly (and appropriately) regulated. It may only be exercised within the context of a behaviour support plan that is tailored to the person's circumstances, which is prepared and regularly reviewed by a practitioner with relevant expertise, and, in the majority of cases, is also approved by specialist panel.[489]

We note that in the draft NSW Persons with Disability (Regulation of Restrictive Practices) Bill 2021, a guardian may act as an 'appropriate trusted person' for a NDIS participant in the context of restrictive practices. As an 'appropriate trusted person', the guardian may give consent to the use of restrictive practices if the guardianship order pertaining to the NDIS participant includes the above-described restrictive practices function.[490]

As discussed in Chapter 1 of this report, it is debatable whether 'consent' is possible for coercive and non-consensual measures, such as restrictive practices. Certainly, this appears as a site of contention in relation to the human rights of people with disability. Moreover, where a guardian agrees to use of a restrictive practice, they are making a decision on behalf of another person to submit to a coercive and non-consensual measure. This approach would certainly be at odds with the requirements of Article 12 CRPD, and general obligation to protect people with disability from violence.

Notably, further to the specified 'restrictive practices function' of guardianship, guardians can also be empowered to make decisions about restrictive practices through other functions. For instance, the 'coercive accommodation function' enables guardians to make decisions to authorise police and ambulance officers to take the person under guardianship and return them coercively to their accommodation. It is also important to recognise that the appointment of a guardian per se is a legal pathway to restrictive practices. This is because, the appointment of a substitute decision-maker (guardian) limits the rights of people with disability to legal capacity, even in circumstances where that guardian has not been provided with the 'restrictive practices' and/or 'coercive accommodation' functions.

Western Australia

A guardian can be appointed by the State Administrative Tribunal of Western Australia if particular criteria are met. The Tribunal must be satisfied that the individual is aged 18 years or older,[491] is 'in need of a guardian',[492] and is:

> (i) incapable of looking after their own health and safety;
>
> (ii) unable to make reasonable judgements in respect of matters relating to [their] person; or
>
> (iii) 'in need of oversight, care or control in the interests of [their] own health and safety or for the protection of other persons'.[493]

A guardian is required to act 'according to the guardian's opinion of the best interests of the represented person'.[494] Acting in the guardian's opinion of best interests includes acting 'as an advocate for the represented person', and doing so 'in such a way as to encourage the represented person to live in the general community and participate as much as possible in the life of the community'.[495] Acting in the guardian's opinion of 'best interests' of the person also includes acting 'in such a way as to protect the represented person from neglect, abuse or exploitation', and 'in the manner that is least restrictive of the rights, while consistent with the proper protection, of the represented person'.[496]

Like New South Wales, a guardian in Western Australia can be appointed as a plenary or limited guardian.[497] A plenary guardian in Western Australia is described as having:

> all of the functions in respect of the person of the represented person that are, under the Family Court Act 1997, vested in a person in whose favour has been made –
>
> (a) a parenting order which allocates parental responsibility for a child; and
>
> (b) a parenting order which provides that a person is to share parental responsibility for a child,
>
> as if the represented person were a child lacking in mature understanding, but a plenary guardian does not, and joint plenary guardians do not, have the right to chastise or punish a represented person.[498]

Limited guardians, like their counterparts in New South Wales, can be given specific functions. Common functions include accommodation, who the person lives with, whether and for who the person works, medical treatment, education and training access, and social contact.[499]

The State Administrative Tribunal of Western Australia has recognised that guardians can have the authority to authorise restrictive practices.[500] To this end, the Tribunal has noted the importance of observing the role of consent to restrictive practices in transforming these interventions from unlawful assault to legally acceptable contact. The Tribunal explained:

> It is important not to lose sight of the fact that, depending on the nature of the restrictive practice in question, its commission, in the absence of consent by, or on behalf of, the person subject to the practice, may have a number of consequences under the law. A restrictive practice which involves the application of physical force of some kind (such as the use of a harness to restrain a person from moving about in, or exiting from, a car) may constitute an assault under the criminal law or a trespass to the person, giving rise to civil law remedies. Similarly, securing residents in a residential facility by locking their bedroom doors, without the consent of, or on behalf of, the residents, may give rise to civil actions for false imprisonment, or to criminal prosecution for deprivation of liberty. In some cases, circumstances of emergency or necessity may excuse the conduct notwithstanding the absence of consent (such as in respect of the provision of medical treatment to a person, in the case of an emergency) so as to relieve the service provider of liability for what would otherwise be an assault to the person. Generally speaking, however, consent to the use of a restrictive practice is essential because '[c]onsent ordinarily has the effect of transforming what would otherwise be unlawful into accepted, and therefore acceptable, contact.'[501]

In the decision of *MS*, the Tribunal considered the issue of whether guardian authorisation of restrictive practices was necessary in the context of the introduction of the NDIS in Western Australia. The Tribunal was of the view that while it was not legally mandated, a guardian's authorisation of restrictive practices would likely be the only option in many cases where a service provider was seeking to use restrictive practices against a NDIS recipient and required someone to consent to such practices. The Tribunal determined that:

> […] in the case of an NDIS recipient who does not have the capacity to consent to the use of restrictive practices, the only mechanism by which that consent may be given will, in many cases, be by the appointment of a guardian under the GA Act, even if the NDIS recipient concerned does not otherwise need a guardian. The requirement that consent be given by a guardian is likely to have the consequence that more NDIS recipients will need to have guardians appointed under the GA Act, in order to receive services under the NDIS scheme. That result exposes a tension between the realities of the NDIS scheme, and one of the key principles of the GA Act, which is that a guardianship order should not be made if the needs of a person (that is, the NDIS recipient) can be met by other means less restrictive of their freedom of decision and action.[502]

Again we note that where a guardian agrees to use of a restrictive practice, they are making a decision on behalf of another person to submit to a 'coercive and non-consensual' measure. This approach would certainly be at odds with the requirements of Article 12 CRPD, and general obligation to protect people with disability from violence. It is therefore concerning that the structure of current regulations imply that if an NDIS service provider determines that a participant does not have the capacity to consent, then this can be a trigger for the appointment of a guardian in order to effect use of restrictive practices. This tension was highlighted in the above Western Australia State Administrative Tribunal case, which pointed to the 'likelihood that more NDIS recipients will need to apply for guardianship orders, or for the amendment of guardianship orders, to expressly permit a guardian to consent to the use of restrictive practices.'[503]

Scholarly engagement with guardianship law

Aligning with the previously espoused view that different forms of disability-specific lawful violence intersect with, and are supported by, social norms and cultural beliefs about disability, guardianship laws in Australia have been heavily critiqued for their paternalistic connotations.[504] This paternalism is arguably most evident in the text of Western Australian guardianship legislation, which explicitly likens the role of a plenary guardian to that of a parent to a child. However, even when guardians are not explicitly likened to parents in contemporary guardianship laws, such as in NSW's guardian legislation, these laws are still critiqued for retaining several other traditional, paternalistic, features, including the 'best interests' principle.[505]

Recently, in recognition of the inappropriateness of this paternalistic principle, some legal jurisdictions in Australia, have begun to move away from the 'best interests' principle. This is especially the case in relation to guardianship law, which is increasingly moving towards a 'will and preferences' framework. This move towards 'will and preference' is often characterised as a shift from a decision-making process that resembles 'substitute decision making' to one that is more closely aligned with 'supported decision making'.[506] Such a move is in keeping with the National Decision-Making Principles recommended by the Australian Law Reform Commission in its final report on *Equality, Capacity and Disability in Commonwealth Laws* in 2014. In that report, National Decision-Making Principle 3 provides that '[t]he will, preferences and rights of persons who may require decision-making support must direct decisions that affect their lives.'[507]

Notably, the move towards the 'will and preferences' framework, and 'supported decision making' more broadly, has also been subject to significant scholarly scrutiny and critique. Indeed, several implementation and operationalisation concerns have been raised by the scholarly community in this regard. We note that the Disability Royal Commission has commissioned a separate research project to consider guardianship laws, with reference to 'supported decision making' approaches and processes. Accordingly, these issues will not be addressed in any detail in this report to avoid duplication. Instead, we simply draw attention to two critiques that hold relevance in the context of restrictive practices.

First, some scholars acknowledge that the successful implementation of supported decision-making and broader support to people with disability is 'dependent on material conditions'[508]; that is, how well legislative mechanisms for supported decision-making 'mobilis[e] public or private resources (such as informal supports of civil society)'.[509] Here we note the findings previously presented in section 4.3 of this report on under-resourced services and supports for people with disability. Such findings raise considerable concerns about the potential for legislative mechanisms for supported decision-making to mobilise sufficient public or private resources.

Second, some have hypothesised that even in jurisdictions where guardians are instructed to give effect to the will and preferences of a represented person insofar as is practicable – as is the case, for example, in the state of Victoria[510] – there remains potential for a 'mismatch

between the risk perception of the decision maker and that of the represented person'. It has been proposed that this 'mismatch' in risk perceptions may result in a decision-making process that still 'resembles "substitute decision making" more than "supportive decision making"'.[511] Here we are reminded of the findings presented in 4.2.4 of this report on perceived 'duty of care'. In particular, the finding that people with disability often experience diminished 'dignity of risk' in everyday practices of disability services, especially in contexts where third parties, such as guardians, have been empowered to make decisions on their behalf. We further note the findings previously presented in section 4.2.2 of the report on institutional cultures of blame and risk management. In particular, as stated in that section of the report, one of the 'persistent stigmatising beliefs' that appears to uphold institutionalisation-era practices of risk management and drive use of restrictive practices, is the belief some staff hold that people with disability are inherently risky and/or dangerous.[512] We explore this stigmatising perception about people with disability being inherently risky and/or dangerous further next, in our consideration of Victoria's *Disability Act 2006.*

4.5.2.2 Disability legislation

In some cases, restrictive practices are authorised explicitly by disability specific legislation. For example, Queensland regulates use of restrictive practices through the *Disability Services Act 2006*; South Australia has just established a legislative framework for the use of restrictive practices; while in 2021, as indicated above, NSW consulted on a draft Bill for proposed new legislation.[513] In this section, we explore the authorisation of restrictive practices under Victorian disability legislation.

In the state of Victoria, the provisions for authorising restrictive practices in relation to adults with disability are provided in the *Disability Act 2006* (Vic). The Act provides for the use of regulated restrictive practices in both NDIS service provision and disability service provision. The Act also provides for use of specific orders that limit the liberty or freedom of movement of people with disability in distinct ways. Below we outline the approval and authorisation process for use of regulated restrictive practices in NDIS service provision, as well as outline the provisions for a unique order made possible through the *Disability Act 2006* (Vic): Supervised Treatment Orders.

Authorisation and approval of restrictive practices in NDIS service provision

In the state of Victoria, authorisation for use of restrictive practices in NDIS service provision typically hinges on the powers and actions of two specified personnel. First, the law provides that an Authorised Program Officer must determine that use of a regulated restrictive practice is: 'necessary' to prevent the person with disability from causing physical harm to themselves or another person;[514] that the option taken is 'the least restrictive';[515] and, that the restrictive practice has been included in the person's behaviour support plan,[516] adhering to the requirements of that plan,[517] as stipulated by the *NDIS* (*Restrictive Practices and Behaviour Support*) *Rules*.[518] Second, the law further provides that all uses of restrictive practices against a person with disability must have been approved by the Senior Practitioner.[519]

Notably, in relation to the person with disability, the Authorised Program Officer is also charged with ensuring that 'an independent person' explains to the person with disability the proposed use of regulated restrictive practices.[520] The independent person must also explain to the person with disability that they can seek a review of the Authorised Program Officer's decision.[521] If the independent person considers the person with disability to be unable to understand the proposed use of regulated restrictive practices, the independent person may report the matter to the Victorian Public Advocate or Senior Practitioner.[522] We note concerns have previously been raised about the effectiveness of this legislative safeguard for people with disability. For instance, in 2012, the Victorian Office of the Public Advocate's Discussion Paper on restrictive practices in Victoria's disability sector raised the concern that having an independent person '*explai[n]* the inclusion of restrictive interventions is not equivalent to assisting the person with the disability [to] *understand* their use.'[523] The discussion paper further noted that '[i]n the six years since the implementation of the Disability Act [in 2006], the Public Advocate has not received any reports from independent persons about these matters.'[524]

Supervised Treatment Orders

As noted above, one of the unique features of the *Disability Act 2006* (Vic) is its inclusion of provisions for authorising and approving Supervised Treatment Orders (STOs). STOs can only be sought in relation to people with an intellectual disability[525], who are receiving residential services[526], or who are Specialist Disability Accommodation residents[527], and who meet specified criteria. The specified criteria are:

a. the person has previously exhibited a pattern of violent or dangerous behaviour causing serious harm to another person or exposing another person to a significant risk of serious harm;

b. there is a significant risk of serious harm to another person which cannot be substantially reduced by using less restrictive means;

c. the services to be provided to the person in accordance with the treatment plan and an NDIS behaviour support plan, as the case requires, will be of benefit to the person and substantially reduce the significant risk of serious harm to another person;

d. the person is unable or unwilling to consent to voluntarily complying with a treatment plan and an NDIS behaviour support plan, as the case requires, to substantially reduce the significant risk of serious harm to another person;

e. it is necessary to detain the person to ensure compliance with the treatment plan and an NDIS behaviour support plan, as the case requires, and prevent a significant risk of serious harm to another person.[528]

The application for an STO is made by an Authorised Program Officer,[529] but the Senior Practitioner is empowered to direct the Authorised Program Officer to make the application.[530] The application for an STO is received by the Victorian Civil and Administrative Tribunal

(VCAT), and must include a 'treatment plan' and a NDIS behaviour support plan approved by the Senior Practitioner.[531] The treatment plan must specify the treatment to be provided, the 'expected benefits to the person', the restrictive practices to be used, the level of supervision required to 'ensure the person participated in the treatment', and the proposed process for transitioning off the STO.[532]

If VCAT determines that the person with intellectual disability meets the above listed criteria, they can make a STO. An STO may be in force for a period 'not exceeding 1 year'[533]. There is 'no limit on the number of applications that can be made'.[534] In practice this means that some people with intellectual disability have become subject to continuous detention by reason of consecutive application and renewal of STOs.[535]

STOs are a significantly under-researched area of disability law. Indeed, the only scholar who appears to have engaged with this area of disability law is Claire Spivakovsky. [536] Spivakovsky observes that STOs have potentially discriminatory effects, and may provide ways to justify abuses of human rights under the guise of paternalistic 'protection'.[537]

4.5.2.3 Family Court welfare jurisdiction (Commonwealth)

As noted in section 4.5.1, some legal pathways only apply to particular populations, or are often used in relation to particular restrictive practices. STOs, discussed above, represent one such example, applying only to people with an intellectual disability in Victoria, and being used specifically to detain a person for the purposes of coercive 'treatment'. The Family Court welfare jurisdiction – to which we turn now – provides another example.

The Family Court welfare jurisdiction applies only to children, and has been utilised particularly in relation to sterilisation of girls with disability. Indeed, there are numerous published decisions concerning the use of the Family Court's welfare jurisdiction in relation to sterilisation of children.[538] Here it is worth clarifying that the Family Court's welfare jurisdiction applies only to 'non-therapeutic sterilisation'. Parents have the authority to consent on a child's behalf to 'therapeutic' sterilisation without seeking court authorisation.[539] Here, 'therapeutic' sterilisation is defined as sterilisation that is a 'by-product of surgery appropriately carried out to treat some malfunction or disease'.[540]

Authorisation of parental consent to non-therapeutic sterilisation occurs pursuant to s 67ZC of the *Family Law Act 1975* (Cth). This section provides that the Family Court has 'jurisdiction to make orders relating to the welfare of children'.[541] Section 67ZC further provides that in deciding whether to make such orders 'a court must regard the best interests of the child as the paramount consideration'.[542] In determining what is in a child's 'best interests', s 60CC(1) of the *Family Law Act 1975* (Cth) provides that the Family Court must have regard to a range of primary considerations and additional considerations.[543] In *Re Marion* (*No 2*), the Chief Justice Nicholson of the Family Court identified a number of relevant factors in that case which went to determining whether the procedure was in the best interests of the child. These factors included:

i. the particular condition of the child which requires the procedure or treatment;

ii. the nature of the procedure or treatment proposed;

iii. the reasons for which it is proposed that the procedure or treatment be carried out;

iv. the alternative courses of treatment that are available in relation to that condition;

v. the desirability of and effect of authorising the procedure or treatment proposed rather than the available alternatives;

vi. the physical effects on the child and the psychological and social implications for the child of:

    a. authorising the proposed procedure or treatment

    b. not authorising the proposed procedure or treatment

vii. the nature and degree of any risk to the child of:

    a. authorising the proposed procedure or treatment

    b. not authorising the proposed procedure or treatment

viii. the views (if any) expressed by:

    a. the guardian(s) of the child;

    b. a person who is entitled to the custody of the child;

    c. a person who is responsible for the daily care and control of the child;

    d. the child to the proposed procedure or treatment and to any alternative procedure or treatment.[544]

Importantly, while the Family Court's welfare jurisdiction has been utilised particularly in relation to sterilisation of girls with disability, it should be noted that this jurisdiction has a broad use. Indeed, the welfare jurisdiction has been used to authorise other 'special medical procedures' outside of parental authority. Some examples of 'special medical procedures' authorised by the Family Court include: bone marrow transplant between infant cousins,[545] administration to a baby of an unapproved therapeutic drug to treat a rare and fatal metabolic disorder,[546] and gender affirmation treatment and surgery for transgender young people.[547] Thus it is necessary to clarify that the Family Court's welfare jurisdiction is not exclusively used for the purposes of making judgments about sterilisation, nor is it used exclusively in relation to children with disability. Indeed, the broad reach of the Family Court's welfare jurisdiction in acting in relation to the 'best interests' of children has been likened by Mason CJ, Dawson J, Toohey J and Gaudron J in *Marion's Case* to the *parens patriae* jurisdiction of the Supreme Court.[548] We consider the *parens patriae* jurisdiction separately in the next section.

Notably, like guardianship law, the Family Court's welfare jurisdiction's paternalistic emphasis on acting in the 'best interests' of children has been subject to scholarly critique. As explained by

John Chesterman in relation to both guardianship law and child welfare legislation, the phrase 'best interests':

> has come to acquire a meaning that is almost contrary to the original intentions behind its usage. Its frequent use in child welfare legislation, in particular, has seen it acquire quite paternalist connotations. It is inevitable, perhaps, that the regular usage of the principle of 'best interests' to override a person's expression of their wishes would mean that the phrase has come to be a euphemism for overriding someone's free will.[549]

On this point by Chesterman about the paternalist connotations of guardianship and child welfare legislation, we note that Family Court approvals of sterilisation during the 1980s and 1990s were perhaps even more paternalistic than guardianship decisions of that time. Indeed, Jennifer Ford provides the example of the sterilisation of 'L', a 17 year old girl with 'severe developmental disabilities as a consequence of Smith-Magenis syndrome'.[550] Ford explains that 'L's parents applied to the NSW Guardianship Board in the mid-1990s for consent to 'hysterectomy, on the basis that her behaviour became worse immediately prior to and during menstruation, that she was adversely affected by the sight of blood, and that she had particularly heavy bleeding'.[551] The NSW Guardianship Board rejected the application because a hysterectomy was not a 'step of last resort' by reason of alternative, less invasive, options for managing menstruation.[552] The parents then successfully applied to the Family Court.[553]

4.5.2.4 Parens patriae jurisdiction of the Supreme Court (focus on New South Wales)

The *parens patriae* jurisdiction is a Supreme Court jurisdiction in which the State makes decisions for the care of individuals who are not able to care for themselves. Typically, this categorisation includes children and adults with cognitive and psychosocial disability who are viewed as lacking capacity to make their own decisions about their health and welfare.

Restrictive practices come within the scope of the *parens patriae* jurisdiction. Under the NSW Supreme Court, the *parens patriae* jurisdiction is used to authorise restrictive practices on children and young people. These orders are referred to as 'secure accommodation orders' – that is, when a child or young person is detained in a locked residential facility and can be returned to that facility by use of force – and 'restrictive intervention orders' – that is, when a child or young person can be subject to use of force to precent harm to self or others. We note the similarities here between the 'secure accommodation' and 'restrictive intervention' orders for children and young people under the New South Wales Supreme Court's *parens patriae* jurisdiction, and the 'coercive accommodation' and 'restrictive practices' functions of guardianship orders for adults in New South Wales previously described.

Justice Brereton explored the scope of the *parens patriae* jurisdiction in relation to secure accommodation orders in *Re Thomas*. Here Justice Brereton noted that the jurisdiction is broader than parental powers over children, and is broader than any available legislative

provisions. As such, Justice Brereton noted the *parens patriae* jurisdiction could extend to indefinite detention of a child:

> In the present proceedings, the Director-General seeks permission to detain Thomas indefinitely in a secure unit, and to restrain and medicate him as the circumstances may require. There is no statutory provision that authorises, or provides for, the detention of a child as an ongoing "non-temporary" aspect of his or her treatment and protection (s 158 of the Care Act, while authorising detention for some purposes, permits it only on a temporary basis). The present application is made on the premise that the proposed arrangements – in particular, insofar as it is proposed to confine Thomas in secure accommodation indefinitely – involve acts or procedures beyond the ordinary scope of parental power, so as to require the sanction of the Court as parens patriae. I agree that the indefinite confinement of a 15-year-old child in secure premises that he cannot leave of his own volition is beyond the ordinary scope of parental responsibility, and requires the sanction of the Court. While it can be accepted that parents have authority to interfere or restrict the liberty of their children to some extent, I cannot think it extends to the indefinite confinement of a 15-year-old. However, for the reasons that follow, I am satisfied that, within its wide parens patriae jurisdiction – under which the powers of the Court are more extensive than those of parents – the Court may authorise such confinement.
>
> The breadth of the jurisdiction has often been emphasised; indeed it has been said that it is without limitation, although to be exercised with caution.
>
> The jurisdiction is founded on the need to act for the protection of those who cannot care for themselves. Although it has been most frequently invoked in the context of medical treatment, the parens patriae power is not limited to therapeutic treatment.[554]

Notably, as Justice Brereton's words suggest, the exercise of the *parens patriae* jurisdiction in relation to restrictive practices is framed in terms of child welfare, rather than disability behaviour support. However, in conducting a review of judgments publicly available in Austlii – the Australian legal database where published court decisions can be accessed – we found that nearly all publicly available judgments at this time relate to children and young people with disability diagnoses. Accordingly, although the *parens patriae* jurisdiction's authorisation of interventions are legally and administratively categorised in terms of 'children', and not 'disability' per se, this categorisation does not undermine the reality that the jurisdiction is being used to authorise restrictive practices on people with disability.

Writing nearly 30 years ago in 1994, John Seymour noted the broad nature of the *parens patriae* jurisdiction as it applies to the interests of children. Seymour explained:

> On the one hand, it allows a court to intervene to make decisions which are of a kind normally made by a parent, but which, for some special reason, are outside parental competence. On the other, it permits intervention in a miscellaneous range of situations which often (but not invariably) involve persons outside the family. In combination,

> these two facets of the jurisdiction confer extraordinarily broad powers. A court exercising them is free to act as a deus ex machina, intervening whenever this is thought to be in a child's best interests.[555]

Indeed, Seymour characterises *the parens patriae* jurisdiction as 'capacious', stating that historical analysis reveals that:

> Whenever new circumstances have arisen in which intervention might be justified to protect children's welfare, the Judges – while sometimes refusing to exercise their powers – have never sought to circumscribe the jurisdiction. The result has been the fashioning of a capacious jurisdiction.[556]

In the boxed case study below, we consider this observation by Seymour in the context of contemporary *parens patriae* jurisdiction decisions. Specifically, we consider the operation of the *parens patriae* jurisdiction in relation to adult guardianship and transitions into NDIS service provision arrangements. Here we provide overviews of three decisions where the *parens patriae* jurisdiction has been made available for use for people with disability over 18 years of age due to concerns about guardianship provisions. We include this case study of decisions pursuant to the *parens patriae* jurisdiction because the NSW Supreme Court's *parens patriae* jurisdiction often affects children with disability in out-of-home care, including First Nations young people with disability in out-of-home-care.[557] As explained at various points throughout the report, there is little to no academic research to date that considers the role and use of restrictive practices in the context of children and young people with disability in out-of-home care. Consideration of these three decisions thus offers insight into the legal pathways enabling restrictive practices for this marginalised cohort of young people with disability. Following this case study we offer some final engagement with the intersections of disability-specific lawful violence and socio-cultural norms of paternalistic 'protection'.

Case Study

Transitioning young people with disability in out-of-home care from orders pursuant to the NSW Supreme Court's *parens patriae* jurisdiction onto adult guardianship arrangements

The NSW Supreme Court's *parens patriae* jurisdiction often affects children and young people with disability, including those in out-of-home care. It is, however, important to recognise that are also a number of decisions pursuant to the NSW Supreme Court's *parens patriae* jurisdiction that relate to young people turning 18 years of age. Some of these decisions concern the transition of a young person with disability onto NDIS and guardianship arrangements. These decisions are significant for two reasons.

First, in drawing attention to the transition between the legal pathways to authorise restrictive practices for children, and the legal pathways to authorise restrictive practices for adults, these decisions offer insight into the life-course of legally authorised restrictive practices that some people with disability experience. Second, these decisions demonstrate that the *parens patriae* jurisdiction is available for use for people who are aged 18 years and over, despite the availability of guardianship legislation to authorise restrictive practices for adults with disability. As detailed below, one of the reasons the *parens patriae* jurisdiction is said to be justified for continued use once a person has reached adulthood is because of issues relating to guardianship and NDIS arrangements.

Below we consider three decisions where the *parens patriae* jurisdiction is made available for use for people over 18 years of age. We note there are other publicly available decisions concerning the transition from the NSW Supreme Court's *parens patriae* jurisdiction onto adult guardianship arrangements.[558] However, the issues of significance described above are best captured in the three decisions summarised below.

Re Lee

In the Supreme Court decision of *Re Lee*, Lee was due to turn 18 in two days and was under the parental responsibility of the Minister until she reached 18 years. In this decision, Justice Brereton notes that '[n]ormally, in a case such as this, when the parental responsibility order expires, it is replaced by a guardianship order made by the NSW Civil and Administrative Tribunal.'[559] In Lee's case, however, Justice Brereton determines that the Court should retain supervision of her care for a period following her 18th birthday. In explaining the basis for this decision, Justice Brereton outlines two core issues of concern.

First, Justice Brereton was concerned that the guardianship order sought was not sufficient in its scope of control over Lee (as compared to the existing *parens patriae* orders). The guardianship order sought did not confer any power to detain Lee, nor did it contain power to make decisions about medical treatment including contraception.[560] The lack of decision-making power relating to contraception was of particular concern to Justice Brereton. In relation to this point Justice Brereton noted that 'one of the important issues concerning Lee is her apparent determination to become pregnant as soon as possible'.[561] It was believed that if Lee became pregnant, this 'would almost certainly result in the child's removal into care at birth, with consequent enormous adverse psychological impacts for Lee'.[562]

A second concern for Justice Brereton was the apparent lack of engagement by the Public Guardian with the Secretary. This lack of engagement raised questions for Justice Brereton about how the transition of Lee's arrangements would be effectively managed, and how the 'Public Guardian might gain an appreciation of the issues'.[563]

Notably, in making this decision about Lee, Justice Brereton clarifies that the making of a guardianship order per se does not mean the *parens patriae* jurisdiction is unavailable. Rather, the *parens patriae* jurisdiction could still apply to people with disability even after they turn 18. As Justice Brereton states 'The circumstance that a child attains majority does not mean that the power ceases to be available, at least where upon attaining adulthood she remains incapable.'[564] In the case of Lee, it is determined that 'the very fact that a guardianship order has been made at all is some indication that Lee still lacks that capacity, and there is ample evidence in the present proceedings to show that Lee's lack of capacity is not merely attributable to age, but to serious psychological disorders.'[565]

Re Anita (*No 3*)

Re Lee was subsequently considered by Justice Robb in the decision of *Re Anita* (*No 3*). Anita was in the care of the Minister pursuant to the *parens patriae* jurisdiction. Anita had, however, recently turned 18, and was transitioning to a disability service provider. A guardianship order had been made for Anita, appointing the Public Guardian with the following functions: advocacy, access (to decide what access Anita has to others and the conditions of access), accommodation (to decide where Anita may reside and to authorise NSW Police and the Ambulance Service of NSW to take her and return her to that accommodation), restrictive practices (to make decisions about access to sharps, access to personal belongings, access to the community and use of PRN medication), and services (to make decisions about the services to be provided to Anita).[566]

In *Re Anita* (*No 3*), Justice Robb declined to dismiss a summons seeking orders that would have ended the exercise of the power and responsibility under the *parens patriae* jurisdiction. Instead, Justice Robb adjourned the proceedings to give time for completion of the transition of responsibility of Anita from community services to disability services. In so doing, Justice Robb stated that the 'court may exercise its jurisdiction to supervise and facilitate an orderly and appropriate transition from one administrative arrangement to another.' [567]

In coming to this decision to supervise and facilitate the transition of Anita between administrative arrangements, Justice Robb clarifies that the making of a guardianship order does not displace the court's jurisdiction. Indeed, Justice Robb states that in this circumstance, the *parens patriae j*urisdiction is preserved 'in order to deal with unforeseen or extraordinary problems, as a means of aiding statutory decision-makers in the due performance of their functions'. [568]

Notably, similar to Justice Brereton in *Re Lee*, Justice Robb in *Re Anita* (*No 3*) offered clarity regarding the tension between age and disability under the *parens patriae* jurisdiction. Here Justice Robb states that the need to exercise this jurisdiction continues

for Anita after she has reached adulthood because 'her need for protection has not materially abated'.[569] Specifically, as Justice Robb clarifies this need for protection has not changed because 'Anita's need for protection arose almost entirely as a result of her mental disabilities, and not out of her minority.'[570]

Re Millie

In *Re Millie*, Justice Slattery considered transition arrangements for Millie who was soon due to turn 18 years old. Millie was described as having a diagnosis of 'in utero exposure to drugs and alcohol with consequent dysexecutive syndrome', 'complex cumulative and enduring post-traumatic stress syndrome due to neglect and abuse in her early developmental period', 'bi-polar disorder', and 'other syndromes and deficits that it is not necessary to detail'.[571]

Justice Slattery was of the view that the *parens patriae* jurisdiction would no longer apply to Millie once she reached adulthood, stating 'the time has come for Millie to leave the Sherwood House facility. The Court's *parens patriae* jurisdiction over her will soon expire'.[572] However, Justice Slattery adjourned the matter due to NDIS arrangement delays.

In a decision two months later, it was indicated that Millie had now turned 18 and had a Public Guardian appointed, but NDIS arrangements had still not been finalised. The plaintiffs (the Secretary of the Department of Family and Community Services and the Minister) and Millie's independent children's representative all applied for the existing orders pursuant to the *parens patriae* jurisdiction to continue for a further short period while the arrangements were finalised. Contrary to Justice Slattery's previous decision in relation to Millie, in this decision Justice Slattery was of the view the *parens patriae* jurisdiction could and would continue, citing *Re Anita* (*No 3*), and *Re Lee*.

Two months later, in another decision, Justice Slattery discharged the secure accommodation orders pursuant to the *parens patriae* jurisdiction in relation to Millie. This decision was primarily made because 'the Court is confident on the evidence that the Public Guardian has been able to establish a sound relationship with Millie', and because the 'the National Disability Insurance Agency ("NDIA") has now made decisions to fund fully supported independent living accommodation ("SIL") for Millie'.[573]

4.5.2.5 Paternalistic 'protection' and the CRPD

While there are clear differences between the specific legal tests or the principles framing each of legal pathways reviewed in this section of the chapter, at a general level, these pathways appear to share a focus on authorising interventions considered to be in the 'best interests' of the person with disability, and/or place an emphasis on 'protecting' said person from harm. Importantly, these paternalistic connotations of 'best interest' and 'protection' are not unique to the four pathways to authorising restrictive practices reviewed above. Rather, scholars have made similar critiques in relation to other pathways to restrictive practices not considered here. Indeed, it is commonly said that mental health law is based on the paternalist connotations of the doctrine of *parens patriae* coupled with the police powers of the state to prevent harm to the community.[574] As a result, as Piers Gooding has observed, 'protection remains a major driver' in contemporary mental health law 'both in terms of addressing risk – whether real or imagined – to the broader public, or to people at risk of harm to themselves.'[575] Crucially, as Genevra Richardson emphasises, even if some people may approve of the goal of protection, and therefore accept that some level of intervention in a person's autonomy may be required in specific instances, there remains 'no justification for singling out mental disorders for these special powers.'[576] Indeed, as Richardson clarifies, in most jurisdictions, a person who is perceived as 'competent', 'is free to refuse treatment even if her own death will almost certainly result.'[577]

The above observation by Richardson returns our attention to the rights of people with disability. To this end, we note that the various iterations of paternalistic 'protection' threaded through the multiple legal pathways to restrictive practices outlined above are contrary to the CRPD principles of autonomy and self-determination and rights to equality and non-discrimination, independent living and community inclusion, and legal capacity. All of these CRPD principles are about recognising the entitlement of people with disability to make their own decisions about their bodies and lives.

The UN Special Rapporteur on the Rights of Persons with Disabilities has noted in the context of armed conflict that protection of people with disability must not slip into paternalism. He explains that '"protection" in the [CRPD] is part of a broader agenda of personhood, inclusion and participation: a vision of active human agency'.[578] The UN Special Rapporteur elaborated:

> Protection, as such, has not gone away. It is embraced by the Convention (see art. 16, on freedom from exploitation, violence and abuse). However, it is now shorn of its paternalistic roots. In a way, it is acknowledged in the Convention that there is no such thing as an inherently vulnerable person, but only persons with disabilities placed in vulnerable situations. The need to deal with this imposed vulnerability is therefore highlighted. [...] An end to impunity is also demanded in article 16. Accordingly, the historic invisibility of persons with disabilities in law enforcement is acknowledged and its reversal sought.
>
> The Convention therefore does not eliminate the need for protection, but places it on fundamentally different predicates. This has clear implications for laws and policies along

> the peace continuum that seem to overemphasize the medical condition of disability and downplay the moral agency of persons with disabilities, as well as the broader skein of rights into which protection should be understood.[579]

While the UN Special Rapporteur's report is focused on protection in the context of armed conflicts, his discussion of paternalism and protection has broader application. The UN Special Rapporteur's observations suggest that protection must be directed towards supporting people with disability to enjoy inclusion, personhood, participation and agency, and not involve actions which are themselves dehumanising, segregating, exclusionary, non-consensual, coercive, discriminatory, or which otherwise undermine the autonomy and humanity of people with disability.

4.5.3 Liability, redress and access to justice challenges

In section 4.5.1 we introduced the concept of 'disability-specific lawful violence' to make sense of the ways that restrictive practices act as a form of violence that targets people with disability, and which occur irrespective and even because of their legal permissibility. In section 4.5.2 we reviewed some of the legal pathways that authorise, and thus enable, restrictive practices. There we paid particular attention to some of the cultural assumptions about disability that work to mask or justify the violence and rights violations people with disability are subject to through use of restrictive practices. In this third section on law's role as an enabler of restrictive practices we bring attention to two related, final points of tension: the absence of liability and redress when restrictive practices are utilised pursuant to law, and compounding access to justice challenges that may impact a person with disability's ability to seek justice for non-lawful uses of restrictive practices.

4.5.3.1 Absence of liability and redress for lawful uses of restrictive practices

When restrictive practices are utilised pursuant to law, there is an absence of liability and redress for people with disability subject to these practices. Indeed, when restrictive practices are utilised pursuant to law, individuals that use them are not at risk of criminal or civil liability for assault or false imprisonment by reason of their use alone. Similarly, the individuals who authorise their use, the organisations that oversee their use in their services, or the judges and legal professionals involved in their authorisation are not open to any negative legal repercussions. In some cases, people have articulated rights to review, such as the dispute resolution facilities available in some jurisdictions, such as under Sections 23Y and 23Z of the South Australian *Disability Inclusion Act 2018*.[580] But such mechanisms are administrative in character and not equivalent to the justice that might be available through police and courts in relation to criminal assault. This means that at this time, restrictive practices can be carried out with a degree of 'impunity' and certainly do not mirror legal liability and redress that might apply in other circumstances. In his dissenting judgment in *P v P*, Brennan J recognised some of these points of tension; Brennan J stated:

> Perhaps it should not be left out of account that if a child who is sterilized pursuant to an order made by a judge of a superior court learns what has been done to her and complains, she has no redress. The judge bears no responsibility for the carrying out of the order; the surgeon, anaesthetist and staff who act under a judicial order in sterilizing a child are protected by the order.
>
> Although these are very general considerations they are nonetheless important for they influence the path of legal development. They are relevant because this case may be used as an analogy in future cases where a question arises as to the power of judges to authorize the invasion of a person's physical integrity.[581]

It could be argued that the inability for people with disability subject to restrictive practices to obtain justice and remedies for the violence and violations they experience reflects people with disability being abandoned by the justice system. That is to say, it constitutes what Stauffer refers to as 'ethical loneliness': 'the experience of having been abandoned by humanity compounded by the experience of not being heard'.[582] To this end we might observe that individuals subjected to restrictive practices are legally positioned as non-victims. Victim-survivors of restrictive practices cannot seek protection of the criminal justice system and redress through the civil justice system. Nor can victim-survivors of restrictive practices seek support through victims support schemes following lawful use of restrictive practices.

4.5.3.2 Access to justice challenges for non-lawful use of restrictive practices

Even where restrictive practices are utilised in a manner that is not pursuant to current law – that is, unauthorised use – people with disability may still face compounding access to justice challenges. These challenges can impact the ability of people with disability to achieve justice and redress for the non-lawful uses of restrictive practices they have experienced. We note that a more detailed engagement with the distinction between 'authorised' and 'unauthorised' uses of restrictive practices is provided in the next Chapter, section 5.3.2, alongside significant discussion of some of the tensions this distinction brings forth. Below we provide a brief overview of five compounding access to justice challenges people with disability may face when seeking redress for non-lawful uses of restrictive practices.

First, as this report has previously noted, people with disability are subject to the greatest use of restrictive practices in segregated and congregated contexts where people with disability are clustered together. When restrictive practices are used in these settings, in order to access the police, or legal or advocacy assistance or access complaint and justice systems, people with disability might be dependent on the support of staff in those settings, including those who might be potentially found liable following an individual's efforts. Thus, there is the risk of gatekeeping by staff to regulate and even prevent access to justice. There is also a risk, as illustrated in the case study of Tina in section 3.4, that family members who question or oppose use of

restrictive practices become positioned as problems by services and even potentially prevented from further contact with their family member the subject of restrictive practices through the service seeking a guardianship order.[583]

Second, people with disability experience discrimination when reporting violence to police. As Leanne Dowse, Simone Rowe, Eileen Baldry and Michael Backer concluded in their research report for the Disability Royal Commission into police responses to people with disability:

> There is unequivocal alignment in the evidence emerging from the literature, the review of current police policy and practice and the views of Australia's leading advocates that while some individual police demonstrate good practices and approaches, on a systemic basis police do not respond effectively to promote safety and protect people with disability who are victims, witnesses and alleged offenders.[584]

These problems with police responses to people with disability can be exacerbated for individuals with disability who are First Nations peoples or who are from culturally and linguistically diverse backgrounds,[585] or who are women[586].

Third, where unauthorised restrictive practices are used in the context of the NDIS system, there is no process for persons with disability subjected to them to be automatically provided with access to independent and free legal and advocacy assistance and financial resources to seek remedies and victim support services. This lack of process is compounded by the problem that the NDIS Quality and Safeguards Commission regulatory legislative framework does not provide redress as of right to individuals subjected to unauthorised restrictive practices. As will be discussed further in Chapter 5, during the one-year period of 1 July 2020 to 30 June 2021, 7,862 people with disability had been subjected to a total of 1,032,064 unauthorised uses of restrictive practices.[587] The annual report of the NDIS Quality and Safeguards Commission does not indicate if any individuals have been provided access to legal, advocacy or victims support, nor does it report any access as of right to a redress scheme or court action for their exposure to this violence. This is so, even when individuals with disability might not be aware they have been subjected to unauthorised restrictive practices, and this knowledge – which could then be the basis for seeking compensation or other redress and legal protection, some of which has strict timeframes in which to access – is held only by those in positions of authority and power, such as the NDIS service provider and the NDIS Quality and Safeguards Commission.

Fourth, as has been identified by the Disability Royal Commission in its Interim Report, often people with disability are socioeconomically disadvantaged:

> People with disability experience high levels of socio-economic disadvantage and are more likely than people without disability to experience poverty, financial hardship and unemployment, with lower incomes and higher costs associated with living with disability.[588]

Thus, people with disability might encounter financial barriers to accessing legal advice and representation, and the risk of adverse costs orders might prevent them from bringing civil legal action in relation to use of restrictive practices.

Fifth, as discussed by the Australian Law Reform Commission, even if a person with disability has the social capital and financial resources to bring civil legal action, they might not be considered to have the legal capacity to participate in civil proceedings,[589] or to give sworn evidence.[590]

In summary, across the past three sub-sections of this chapter, we have demonstrated how law acts as a core enabler of restrictive practices. We have both illuminated some of the multiple legal pathways for the authorisation of restrictive practices, and demonstrated how these pathways can and do differ depending on jurisdiction, service context and 'consent' of the person. In so doing, we have shown that while law enables use of restrictive practices, the source of this authorisation will vary based on context, thus resulting in a complex and inconsistent system. This complex and inconsistent system holds broad consequences for people with disability, including the absence of liability and redress for the harm caused through use of restrictive practices.

4.6 Summary and conclusion

This chapter has explored dynamics of the use of restrictive practices – specifically four drivers and one enabler. This chapter has not followed the conventional logic embedded in professional and legal discourse that restrictive practices are used because people with disability exhibit 'behaviours of concern' because they are disabled (i.e., the individual and their disability is the reason restrictive practices are used), because this logic does not reflect the lived experiences and ecological system of restrictive practices we outlined in earlier chapters. Instead, this chapter has turned to academic research literature, particularly empirical research, in Australia and internationally that largely engages with the perspectives and experiences of professionals and staff to establish an evidence-base for a more complex set of drivers and enablers. The evidence base for these more complex drivers and enablers moves beyond the conventional logic described above and highlights a range of factors that shape use of restrictive practices that are clearly outside of individuals' bodies and arise from a combination of: structural and cultural conditions within society towards people with disability, what law makes possible to be done to people with disability, and the actions and choices of other people.

The first driver we explored was the existence and operation of institutional settings for people with disability and enduring congregation and segregation of people with disability in institutions *and* community settings. The evidence-base for this driver established that segregated and institutional settings are conducive to use of restrictive practices, and that this includes group homes and other community-based settings that have emerged out of the closure of the larger scale settings often associated with institutionalisation. Moreover, the power-dynamics within these settings facilitate a broader denial of autonomy and choice to people with disability that results in broader restrictions and violence in these contexts and difficulties resisting use of restrictive practices.

The second driver we explored was workplace concerns. We discussed the empirical evidence base for use of restrictive practice across staff with different levels of experience and training, and irrespective of specific training on reducing and eliminating use of restrictive practices. We also found that use of restrictive practices is driven by institutional cultures of blame and risk management which focus more on the possible ramifications of not acting to prevent perceived risk rather than the actual risks to individuals, including through use of restrictive practices. Closely connected to this factor was staff interpretations of legal obligations and liability – perceived occupational health and safety and duty of care requirements – as necessitating use of restrictive practices to avoid liability and/or injury to others rather than centring the experiences and holistic safety needs of persons with disability.

The third driver was under-resourced services and supports for people with disability. We surveyed empirical research highlighting use of restrictive practices for economic efficiency, including in contexts which are understood by staff and families on the ground as being under-resourced (although we observed the need for greater research on the tension that these contexts of understaffing and under-resourcing can involve disability and aged care services operated by businesses or charities for financial compensation). We also found that restrictive practices can be used in the context of families being deprived of the support and services they require to facilitate the daily living and community participation of their children with disability, this in part being by reason of the individualisation of responsibility for children with disability to families rather than proper recognition of the responsibility and accountability of the state to provide this support.

The fourth driver we considered was socio-cultural attitudes. Ableist views towards people with disability positions people with disability as lesser than and naturally unequal to people without disability. These views legitimate beliefs that people with disability can and should be subject to kinds of interventions we would not tolerate in relation to people without disability. This treatment is often masked as benevolent or protective by reason of paternalistic approaches to people with disability. We also noted that use of restrictive practices in relation to some people with disability is further shaped and rationalised by other forms of prejudice and discrimination, including racism and sexism, and settler colonialism.

Last, we engaged with a different set of empirical data – legislation, court judgments and tribunal decisions – to explore how law acts as enabler for use of restrictive practices. We showed that currently, use of restrictive practices does not routinely give rise to criminal charges and civil litigation. This is because, in most cases, restrictive practices are granted formal authorisation by law, and are perhaps best understood as disability-specific lawful violence. Notably, as we showed, although there are currently multiple legal pathways for the authorisation of restrictive practices, the source of this authorisation will vary based on context, thus resulting in a complex and inconsistent system. This complex and inconsistent system holds significant consequences for people with disability subject to restrictive practices, including the absence of liability and redress for the harm caused by use of restrictive practices.

In the introduction to this chapter, we noted that understandings developed in this chapter build on the experiences and ecological system of restrictive practices described by people with disability and those who are closest to them in Chapters 2 and 3 of this report. Put differently, the drivers and enabler identified in this chapter cannot be understood as separate to the ecological system of restrictive practices outlined in Chapter 3, nor the experiences of restrictive practices this produces for people with disability (described in Chapter 2). To that end, we offer a final update to the ecological system of restrictive practices, as illustrated in Figure 5 on the following page.

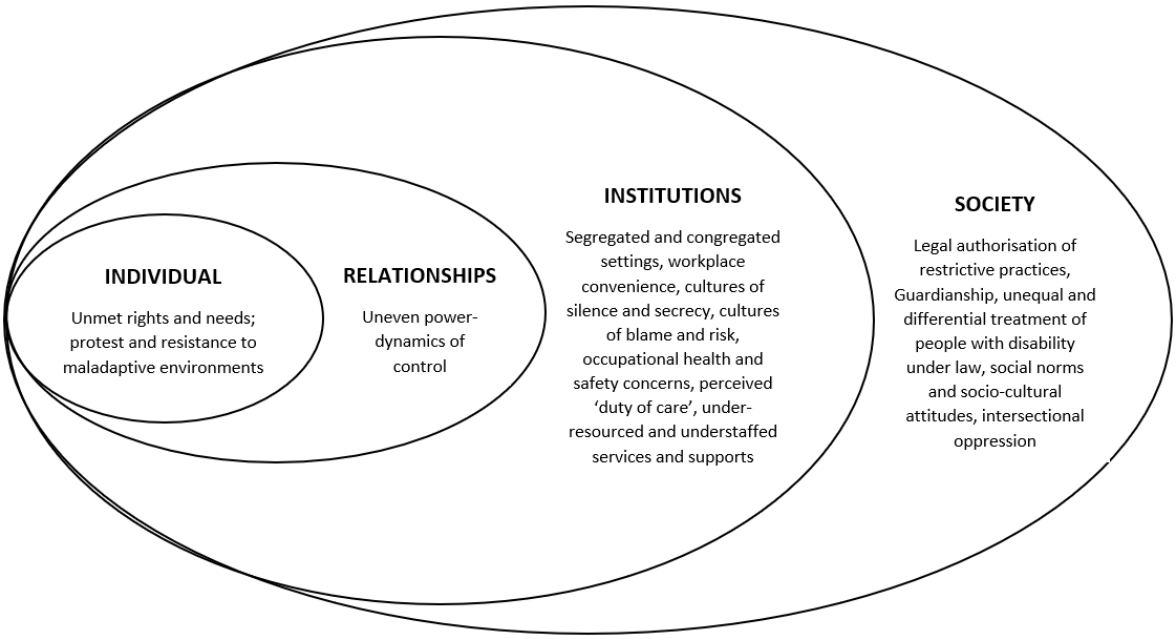


Figure 5: The ecological system of restrictive practices, including key drivers and enabler identified in research literature

In the next chapter we turn to explore whether existing approaches to reducing and eliminating use of restrictive practices respond to the drivers and enablers that facilitate their use, and the broader ecological system of restrictive practices.

Chapter 5: Current approaches to reducing or eliminating restrictive practices

This chapter addresses the second, third and fourth questions set by the Disability Royal Commission for this project. These questions are:

> RQ2: What measures and strategies are most effective in addressing these drivers and reducing or eliminating the use of restrictive practices against people with disability? Does this differ by setting, or by the type of restrictive practice? What measures have been proven ineffective in addressing restrictive practices?
>
> RQ3: Is positive behaviour support effective in reducing and eliminating the use of restrictive practices? Is it more effective in relation to certain types of disabilities, certain restrictive practices, or certain settings?
>
> RQ4: Are there local and international models of policies and practices that have resulted in effective reduction in the use of restrictive practices?

RQ2 is attended to in the first section of the chapter. In that section we focus on the 'high-level' frameworks and principles used to guide current national approaches to reducing and/or eliminating restrictive practices in different systems and service settings. Importantly, as that section of the chapter clarifies, while there are a range of 'high-level' frameworks and principles for reducing or eliminating restrictive practices outlined for implementation in Australia across a range of different settings, including mental health settings, disability services settings and educational settings, it is unclear from current policy and research literature to what extent these frameworks and principles have been developed with consideration of the full range of drivers and enablers of restrictive practices identified in this report. There are also other gaps in knowledge. There has been little to no research conducted to date on the effectiveness of current national approaches to reducing and/or eliminating restrictive practices in specific settings, including if certain frameworks or principles have proven ineffective in addressing restrictive practices. Additionally, it is not possible from the limited material currently available to identify if there are differences in effectiveness between settings. Further research will be required to address these particular areas of interest for the Disability Royal Commission.

What we are able to provide in the first section of this chapter are observations about some of the common features among the 'high-level' frameworks and principles used to guide current national approaches to reducing and/or eliminating restrictive practices in different systems and service settings. We are also able to consider what is known within the broader research literature on the effects of such features.

RQ 4 is addressed in the second section of the chapter. In that section of the chapter, we provide an overview of a selection of 'high-level' frameworks, principles and approaches used to guide international approaches to reducing and/or eliminating restrictive practices.

We further provide detailed case studies of three key international approaches to reducing restrictive practices that have had some success in reducing restrictive practices. These three examples have been adopted by several countries over the years, including, in two of the cases, Australia.

Importantly, all three examples we consider in section two of the chapter were developed in the context of mental health settings. As addressed in that section, while there have been attempts to implement these approaches in other settings, including disability services settings and educational settings, their effectiveness in these other settings has not been evaluated.

RQ3 is addressed in the third section of the chapter. In that section we examine how Australian governments have begun to operationalise the principles and frameworks for reduction and elimination of restrictive practices. Here we draw attention to three core activities associated with this operationalisation: the establishment of a regulation and monitoring regime for restrictive practices; the establishment of an regulatory authorisation regime; and investment in positive behaviour support and behaviour support plans. Our overview of these three approaches to operationalisation includes consideration of Australia's human rights obligations to people with disability, as well as a review of current evidence about the effectiveness of these core developments.

In support of the Disability Royal Commission's interests in the effectiveness of positive behaviour support (RQ3), the third section of the chapter provides a detailed review of the scholarly national and international literature on positive behaviour support. That review identifies five core findings of relevance to the Disability Royal Commission's research interests. Notably, while that review considers the use of positive behaviour support in a range of settings, including schools and adult disability service settings, it is not possible from the research literature currently available to generalise if positive behaviour support is more or less effective in certain settings. Nor is it possible from current research to determine if positive behaviour support is more or less effective when used in relation to certain types of disabilities, or used in the context of certain restrictive practices. Further research will be required to address these particular areas of interest for the Disability Royal Commission.

5.1 Australian frameworks and principles for reducing and/or eliminating restrictive practices

In this first section of the chapter, we provide an overview of the key features of the 'high-level' frameworks and principles that are used to guide national and jurisdictional approaches to reducing and/or eliminating restrictive practices in different systems and service settings. We also identify some common features among these frameworks and principles, and consider what is known within the broader research literature about the effectiveness of such features.

5.1.1 Current national frameworks and principles

Over the past decade, Australia has produced several 'high-level' frameworks and principles to guide national and jurisdictional approaches to reducing and/or eliminating restrictive practices in different systems and service settings. Tables 2 to 6 on the following pages provide a summary of these frameworks and principles. Tables 2 to 6 indicate the setting within which the framework has been developed – disability services, mental health, education, health and aged care. Note, we were unable to identify any publicly accessible frameworks within the justice sector. The Table further outlines the jurisdiction within which the framework or set of principles applies and the core features or guiding principles. Lastly, the Table clarifies if the framework or set of principles was designed to reduce and/or eliminate restrictive practices, and if any measures, indicators or targets have been set to track progress to this end.

Table 2: Australian 'high-level' frameworks and principles for reducing and/or eliminating restrictive practices in disability services settings

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles / Core Features	Targets, Indicators, Measures
National Framework for Reducing and Elimination the Use of Restrictive practices in the Disability Service Sector	Created by the Federal Australian Government with the intention that other levels of government implement appropriate measures	2014	The term 'elimination' appears in the title of this Framework. The body of the text stipulates that the Framework 'focuses on the reduction of the use of restrictive practices in disability services that involve restraint…or seclusion', by establishing a 'national approach' towards this goal.[591]	The high-level guiding principles within the framework include:[592] 1. Human rights 2. Person-centred focus 3. A national approach 4. Delivering quality outcomes and safe workplaces 5. Accountability through documentation, benchmarking and evaluation 6. Collaboration between service providers 7. Raising awareness, providing education and facilitating accessible information.	State jurisdictions should report on their progress towards implementing the Framework principles on a biennial basis.[593] The initial focus was on 'seeking agreement to achieve standardised data collection and reporting' to set benchmarks and performance indicators.[594] Milestones were to then be developed. Any progress to on the development of milestones has not been publicly report. The National Framework was superseded by, and now sits alongside the NDIS Quality and Safeguarding Framework.

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles / Core Features	Targets, Indicators, Measures
NDIS Quality and Safeguarding framework	Produced by the Federal Department of Social Services	2016	States that for the majority of people with disability, it should be possible to reduce and eliminate the use of restrictive practices. It is claimed, however, that for some people this is unrealistic and complete elimination is not possible or for emergency situations.[595]	Proposes a comprehensive approach to reducing and eliminating restrictive practices, which includes: 1. 'Addressing the underlying causes of behaviours of concern by understanding the function of the behaviour, including by ensuring that participants are given the opportunity and support they need to exercise genuine choice and control. 2. Ensuring that the will and preferences of participants are taken into account in decisions that affect them, including through supported decision-making. 3. A legislative framework that governs the use of restrictive practices	Guidance is provided for achieving each of the activities listed in the comprehensive approach to reducing and eliminating restrictive practices.

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles / Core Features	Targets, Indicators, Measures
				4. Building a skilled positive behaviour support workforce to conduct behavioural assessments, develop behaviour support plans in consultation with the person and others who know them well, and work with participants, families and providers to implement plans 5. Supporting providers to adopt best practice approaches to positive behaviour support and ensuring they have access to specialist expertise, guidance and educational resources when needed 6. Overseeing providers supporting people with a positive behaviour support plan, when it includes the use of a restrictive practice	

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles / Core Features	Targets, Indicators, Measures
				7. Overseeing the use of restrictive practices through provider reporting, and 8. Regularly analysing data on use to identify and address systemic issues and assess the success of strategies to reduce use of restrictive practices.'[596]	
National Disability Insurance Scheme (Restrictive Practices and Behaviour Support (Rules) 2018	Delegated legislation created under the *NDIS Act.*	2018	Uses the concept of 'reduce and eliminate'[597]	The rules stipulate that the practitioner producing the Behaviour Support Plan for an individual 'must take all reasonable steps' to incorporate into the Behaviour Support Plan, a strategy to reduce and eliminate the use of restrictive practices for the person they relate to.[598]	All Behaviour Support Plans utilising a restrictive practice must be lodged with the NDIS Quality and Safeguards Commission.[599] NDIS service providers must also regularly (fortnightly/monthly) report their use of the regulated restrictive practices outlined in the Behaviour Support Plan to the Commission.[600]

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles / Core Features	Targets, Indicators, Measures
					Measured progress in reduction and / or elimination of restrictive practices for individuals does not appear to be publicly reported.
Regulated Restrictive Practices Guide	Produced by NDIS Quality and Safeguards Commission	2020	The Guide is designed to 'provide practice advice consistent with a positive behaviour support framework, contemporary evidence informed practice, intended to reduce and eliminate the use of restrictive practices'.[601]	The Guide was intended as a companion to the National *Disability Insurance Scheme* (*Restrictive Practices and Behaviour Support* (*Rules*) *2018*. It provides guidance on legal requirements, definitions of types of restraint, case studies outlining good practice.	No specific measurements or targets outlined.
Positive Behaviour Support Capability Framework	Produced by NDIS Quality and Safeguards Commission	2021	Was intended to 'embed a clear commitment to the reduction and elimination of restrictive practices and a focus on proactive practices'.[602]	The purpose of the Framework is to: 1. 'Define the principles and values base of PBS. 2. Define the key capability domains of best practice PBS in the NDIS context that is person-centred and rights-based.	The Framework outlines 'behaviour support practitioner knowledge', 'behaviour support practitioner skills', and 'service provider and implementing provider considerations'.

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles / Core Features	Targets, Indicators, Measures
				3. Embed a clear commitment to the reduction and elimination of restrictive practices and a focus on proactive practice. 4. Maintain and develop the existing workforce by providing a framework for capability development and career progression. 5. Outline expectations for supervision and continuing professional development within the behaviour support context'.[603]	The Framework further provides indication of the skills and knowledge capabilities considered 'core' to being a behaviour support practitioner, as well as those expected of a practitioner rated as 'proficient' or above.

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles / Core Features	Targets, Indicators, Measures
Targeted Action Plan for Safety under the National Disability Strategy 2021–2023	Produced and agreed to by all Australian governments	2021	Has five objectives. Objective four is to 'reduce and eliminate the use of restrictive practices in all government service systems'.[604]	Key Australian Government actions to achieve this national objective are: 'Work with states and territories to align with the agreed national principles. Progress projects and monitor the implementation of the National Action Plan (NAP): Developing the NDIS Specialist Behaviour Support Market 2020, and report to disability ministers. Progress alignment of regulation of restrictive practices based on best practice across the NDIS and aged care regulators. Increase efforts to continue to educate and build capacity of the disability sector and community sector on behaviour support and the reduction and elimination of restrictive practices.'[605]	Key outcomes and measures at the national level include: 1. 'Consistent national definitions and authorisation processes in place for the use of restrictive practices by 2023. 2. Best practice restrictive practice regulation implemented across the care and support sector, by 2024. 3. Reduction in the use of restrictive practices over time.'[606] The Targeted Action Plan further lists the following additional indicators in relation to restrictive practices at a national level: • 'Education and capacity building tools effectively increase awareness and capacity of the

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles / Core Features	Targets, Indicators, Measures
					disability sector, mainstream systems and the community to eliminate restrictive practices.'[607] • 'People with disability have timely access to quality specialist behaviour support services in a robust behaviour support market.'[608] • 'Consistent and strengthened quality and safety supports in place across the care and support sector that removes unnecessary duplication and regulatory burden for quality standards, auditing and assessment processes, complaints and incident reporting, and behaviour support and restrictive practices, by 2025.'[609]

Table 3: Australian 'high-level' frameworks and principles for reducing and/or eliminating restrictive practices in mental health settings

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles/Core Features	Targets, Indicators, Measures
National Mental Health Commission: Seclusion and Restraint Declaration	Made by the Mental Health Commission	2013	Was a call to action to 'end the seclusion and restraint of children and adults with mental health problems' through reduction.[610]	Was designed to raise public awareness with a range of documents for download.[611] It is unclear if the instrument is still current.	Key targets included: 1. 'Displaying the Declaration at home or in the office. 2. Showing support via social media. 3. Discussing the issues of restraint and seclusion with friends, family and colleagues and encouraging them to sign the Declaration.'[612]
National Targets and Indicators for Mental Health Reform	Report to the Council of Australian Governments (COAG) from its Expert Reference Group on Mental Health Reform	2013	Concerned with reduction and elimination of the use of restrictive practices. The document states: 'We want seclusion and restraint to be eliminated whenever possible. They should be used as an exception because they cause people added trauma'.[613]	The document outlines six targets: 1. 'More people with poor mental health will have better physical health and live longer. 2. More people have good mental health and wellbeing.	Provided recommendations for targets and indicators on reducing restrictive practices: 1. 'Involuntary treatment orders are rare 2. Seclusion rates are reduced by 70% in four years and 90% in 10 years

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles/Core Features	Targets, Indicators, Measures
				3. More people with poor mental health will live a meaningful and contributing life. 4. More people will have a positive experience of support, care and treatment. 5. Fewer people will experience avoidable harm. 6. Fewer people will experience stigma and discrimination.'[614]	3. Restraint: A meaningful baseline measure required for all forms of restraint in four years and then 90% reduction on baseline is achieved in 10 years.'[615]
Framework for Reducing Restrictive Interventions	Produced by the Department of Health of Victoria	2013	The Victorian government has 'a commitment to reducing and, where possible, eliminating restrictive interventions in mental health services.'[616]	The Framework is built around 4 key 'Capabilities' with a range of identified possible actions: 1. Leadership and accountability[617] 2. Facilitating self-determination[618] 3. Workforce[619] 4. Systems[620]	Guidance is provided for how each capability could be facilitated. No specific measurements or targets outlined.

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles/Core Features	Targets, Indicators, Measures
				The Framework further outlines recommendations to be followed as part of 'a program of activity to reduce restrictive interventions',[621] including: 1. Organisational assessment. 2. Workforce plan. 3. Review data. 4. Review governance structures. 5. Develop a program. 6. Adapt processes and policies.[622]	
A Case for Change: Position Paper on Seclusion, Restraint and Restrictive Practices in Mental Health Services	National Mental Health Commission	2015	To reduce, and where possible, eliminate the practices of seclusion and restraint.[623]	This paper makes four 'recommendations for driving action' on restrictive practices: 1. Educate mental health practitioners about multi-intervention strategies.[624] 2. Agree uniform definitions, targets and reporting frameworks.[625]	No specific measurements or targets outlined.

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles/Core Features	Targets, Indicators, Measures
				3. Ensure seclusion and restraint practices and interventions are evaluated.[626] 4. A national approach to the regulation of seclusion and restraint.[627]	
National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services	Developed by the Australian Health Ministers' Advisory Council	2016	It is stated: 'after more than ten years of reduction activities […] these national high-level principles aim to establish a consistent best practice approach to support the goal of eliminating the use of mechanical and physical restraint by mental health services.'[628]	Intended as guidance, and mental health services are not bound to follow them.[629] The principles cover:[630] a. Recovery and trauma-informed practice b. Prevention strategies c. Managing escalating behaviours d. Applicable principles during restraint e. Applicable principles post restraint f. Partnerships in practice production g. Training h. Data collection	No measurements or targets specified beyond the suggestion to collect data.[631]

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles/Core Features	Targets, Indicators, Measures
Safe in Care, Safe at Work	Produced for the Mental Health Commission by the Australian College of Mental Health Nurses	2019	It is stated that this document is 'an essential element in the overall strategy to create safer therapeutic environments for consumers and to eliminate seclusion and restraint in mental health services'.[632]	'The project includes a package of documents comprised of: 1. an audit toolkit for services 2. the Australian adaption of the Six Core Strategies checklist 3. and a list of guiding documents to reduce seclusion and restraint'.[633]	Provides evaluative criteria for each of the Six Core Strategies.[634] See section 5.2.2 below for further details.

Table 4: Australian 'high-level' frameworks and principles for reducing and/or eliminating restrictive practices in education settings

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles/Core Features	Targets, Indicators, Measures
Principles for reduction and elimination of restraint and seclusion in Victorian government school	Produced by Department of Education and Training of Victoria	2017	The department suggests that 'These *Principles* set a course to reduce and eventually eliminate, the use of restraint and seclusion in Victorian government schools.'[635] The purpose of the *Principles* document is to outline 'when physical restraint and seclusion are permitted to be used in Victorian government schools and lists practices that are not permitted to be used in Victorian government schools'.[636]	The proposed principles are: 'Department policy (*School Policy and Advisory Guide – Restraint of Student*) restricting the use of restraint or seclusion applies to all students in Victorian government schools. Physical restraint or seclusion must not be used except in situations where the student's behaviour poses an imminent threat of physical harm or danger to self or others; where such action would be considered reasonable in all the circumstances; and where there is no less restrictive means of responding in the circumstances. Restraint or seclusion should be discontinued as soon as the immediate danger has dissipated.	Guidance is provided for acting on each of the principles. No specific measurements or targets outlined.

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles/Core Features	Targets, Indicators, Measures
				Every effort should be made to prevent the need for the use of physical restraint or seclusion. School should never use mechanical restraints or a chemical restraint that restricts a student's freedom of movement or to control behaviour. Any behavioural intervention must be consistent with the *Charter of Human Rights and Responsibilities Act 2006* and also the student's rights to be treated with dignity and to be free from abuse. Physical restraint or seclusion must never be used as punishment or discipline; as a means of coercion or retaliation; or as a convenience. Physical restraint or seclusion should never be used in a manner that restricts a student breathing or harms the student.	

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles/Core Features	Targets, Indicators, Measures
				Any use of physical restraint or seclusion must trigger a review and, if appropriate, a revision of behavioural strategies currently in place to address behaviour that causes harm to self or others. If positive behaviour strategies are not in place, staff should develop them. If students demonstrate behaviour that causes physical harm self or others necessitating the use of physical restraint or seclusion, strategies to address this behaviour should address the underlying cause of purpose of the behaviour. Teachers and relevant school staff should be trained regularly on the appropriate use of affective alternatives to physical restraint and seclusion, such as positive behaviour support.	

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles/Core Features	Targets, Indicators, Measures
				In every instance in which physical restraint or seclusion is used the student must be carefully and continuously monitored to ensure that the physical restraint or seclusion is being used appropriately and that the student, other students and staff are safe. Parents/carers should be informed of the department policy on restraint and seclusion. Parents/carers should be notified as soon as possible following each instance in which physical restraint or seclusion is used with their child/Student. The Department will regularly review and update, as appropriate, policy regarding the use of physical restraint and seclusion.	

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles/Core Features	Targets, Indicators, Measures
				Each incident involving the use of physical restraint or seclusion should be documented writing and specific data collected to add to staff's understanding of the application of the Principles, and will form the review of the policy.'[637]	
Restrictive Practices Policy and Framework	Department of Education of New South Wales	2023	It is stated that 'The NSW Government is committed to the national goal of reducing and eliminating the use of restrictive practices, wherever possible.'[638]	Use of restrictive practices is guided by six core principles:[639] Person centred Least restrictive For the shortest time Helping to reduce and eliminate restrictive practices Monitored Reviewed regularly	Guidance is provided for each of the six principles. No specific measurements or targets outlined. The Policy and Framework document is not currently operational.

Table 5: Australian 'high-level' frameworks and principles for reducing and/or eliminating restrictive practices in health settings

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles/ Core Features	Targets, Indicators, Measures
National Safety and Quality Health Service (NSQHS) Standards	Australian Commission on Safety and Quality Health Service – a federal independent statutory body	2021	Requires that health service organisations have systems that minimise, and where possible eliminate the use of the restraint; as well as have governance and reporting systems to achieve this goal.[640]	Key tasks under the Standards include[641]: 1. Monitoring and documenting the use of restrictive practices. 2. Understand where and when restraint is used in the health service organisation. 3. Benchmark the use of restraint. 4. Demonstrate implementation of strategies to reduce the use of restraint.	In relation to restraint, key tasks include: 1. Understand where and when restraint is used in the health service organisation. 2. Benchmark the use of restraint. 3. Demonstrate implementation of strategies to reduce the use of restraint. 4. Ensure that members of the workforce who implement restraint are trained to do so safely. 5. Monitor and document appropriate observations during and subsequent to restraint. 6. When restraint has occurred, offer debriefing for the people involved, including patients, carers and members of the workforce'.[642]

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles/ Core Features	Targets, Indicators, Measures
					In relation to seclusion, key tasks include: 1. 'Implement strategies to minimise the use of seclusion. 2. Ensure that seclusion is only implemented by members of the workforce who have been trained to implement it safely. 3. Monitor and document appropriate observations during and subsequent to seclusion. 4. Review the use of seclusion within the health service organisation'.[643]

Table 6: Australian 'high-level' frameworks and principles for reducing and/or eliminating restrictive practices in aged care settings

Name	Jurisdiction	Year	Reduce/Eliminate	Guiding Principles/ Core Features	Targets, Indicators, Measures
Quality of Care Principles 2014	Monitored by the federal statutory body the Aged Care Quality and Safety Commission	2021	The Principles were intended as one of the steps to 'eliminate or minimise the inappropriate use of restrictive practices'.[644]	A range of legislative requirements on Aged Care providers that allude to an intent to reduce or eliminate the use of restrictive practices.[645]	No specific measurements or targets outlined.

5.1.2 Common features of national frameworks and principles

As outlined in the introduction to this chapter, the Disability Royal Commission seeks to understand: what measures and strategies are most effective in addressing these drivers and reducing or eliminating the use of restrictive practices against people with disability? Does this differ by setting, or by the type of restrictive practice? What measures have been proven ineffective in addressing restrictive practices? In the Australian context, and elsewhere, much of this information is not currently available.

While the past decade has seen several national and jurisdictional frameworks or principles for reducing and/or eliminating restrictive practices proposed and/or implemented – as demonstrated in Tables 2 to 6 – there has been little to no investigation of the effectiveness of most of these frameworks or principles. This lack of investigation and evaluation means that it is not presently possible to identify if current approaches to reducing or eliminating the use of restrictive practices in Australia are more effective in certain settings, or indeed, if some are ineffective. As stated in the introduction to this chapter, further research will be required to address these particular areas of interest for the Disability Royal Commission.

What is provided in this section of the chapter instead, are three observations about some of the common features among the 'high-level' frameworks and principles used to guide current national and jurisdictional approaches to reducing and/or eliminating restrictive practices in different systems and service settings. We also consider what is known within the broader research literature on the effectiveness of such features in general.

5.1.2.1 A lack of targets and indicators of progress

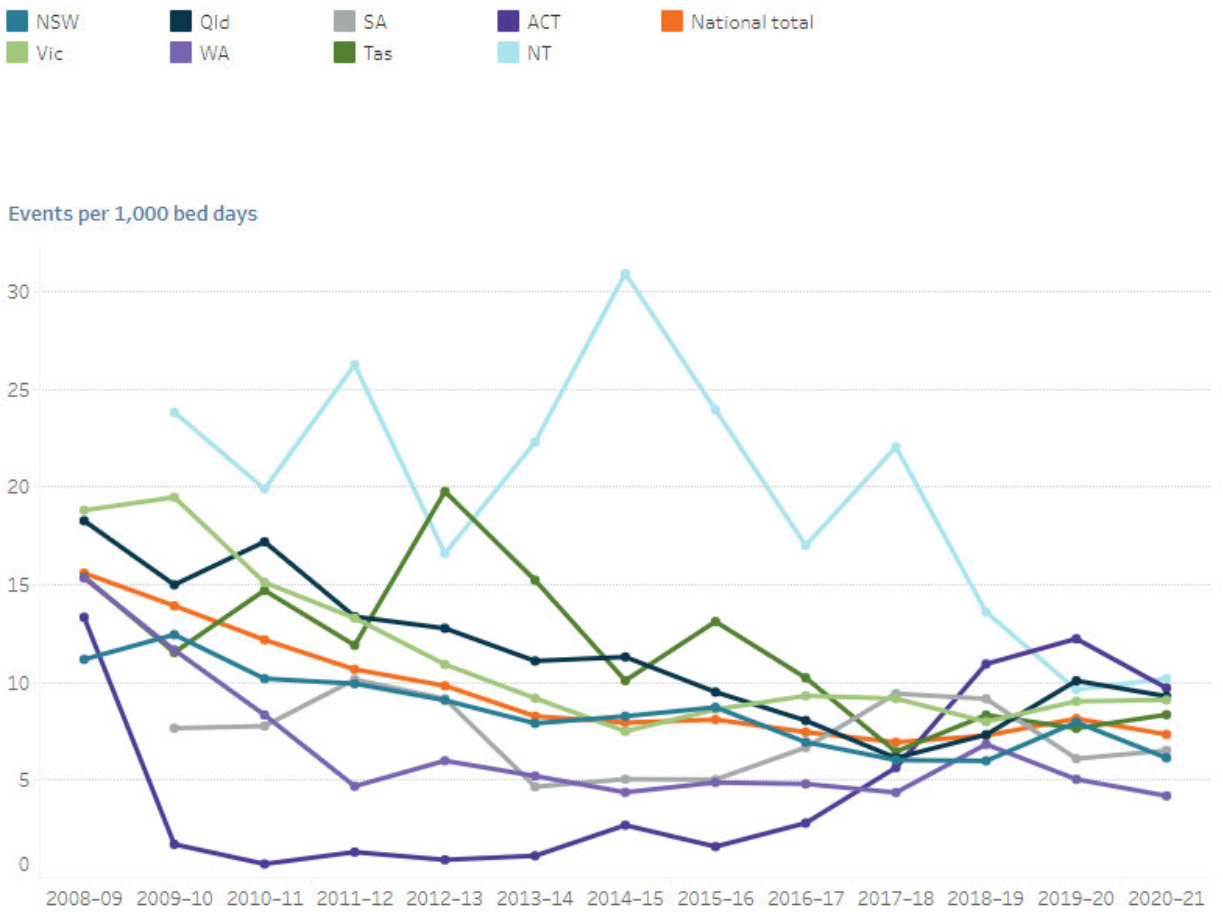
While there is much guidance currently available for implementing the frameworks and principles outlined in Tables 2 to 6, there have been few specific targets or indicators set for reduction and/or elimination. Arguably, the lack of specific targets or indicators set for achieving reduction and/or elimination of restrictive practices contributes to the lack of knowledge currently held about the effectiveness of different measures and strategies. As Tables 2 to 6 indicate, however, there are two strategies and approaches which include specific targets and indicators of progress. We consider these now.

First, in 2013, the Council of Australian Governments' Expert Reference Group on Mental Health Reform published the *National Targets and Indicators for Mental Health Reform.* This document specified the following targets and indicators for reducing restrictive practices in mental health settings:

1. Involuntary treatment orders are rare.
2. Seclusion rates are reduced by 70 per cent in four years and 90 per cent in 10 years.
3. Restraint: A meaningful baseline measure required for all forms of restraint in four years and then 90 per cent reduction on baseline is achieved in 10 years.[646]

We were unable to identify any evaluations of the *National Targets and Indicators for Mental Health Reform,* nor could we identify a schedule for such an evaluation. However, some indication of progress in relation to the targets and indicators specified by the Council of Australian Governments' Expert Reference Group on Mental Health Reform can be found through consideration of data produced by the Australian Institute of Health and Welfare.

The Australian Institute of Health and Welfare provides national data on the use of seclusion and restraint in Australian mental health acute hospital services. Figure 5 below indicates the rates of seclusion in mental health services by states and territories for the period 2008-09 to 2020-21. The figure suggests that rates of seclusion have reduced at a national level since 2008-09. Indeed, the Australian Institute of Health and Welfare data indicates that in the period of 2009-10 to 2020-21, seclusion events in acute specialised mental health hospital services have nearly halved, from 13.9 events per 1,000 bed days in 2009-10 to 7.3 events per 1,000 bed days in 2020-21.[647] The average duration for seclusion in 2020-21 was 5.2 hours.[648] We note that the *National Targets and Indicators for Mental Health Reform* sought a 70 per cent reduction in seclusion events between 2013 and 2017, and a 90 per cent reduction by 2023.

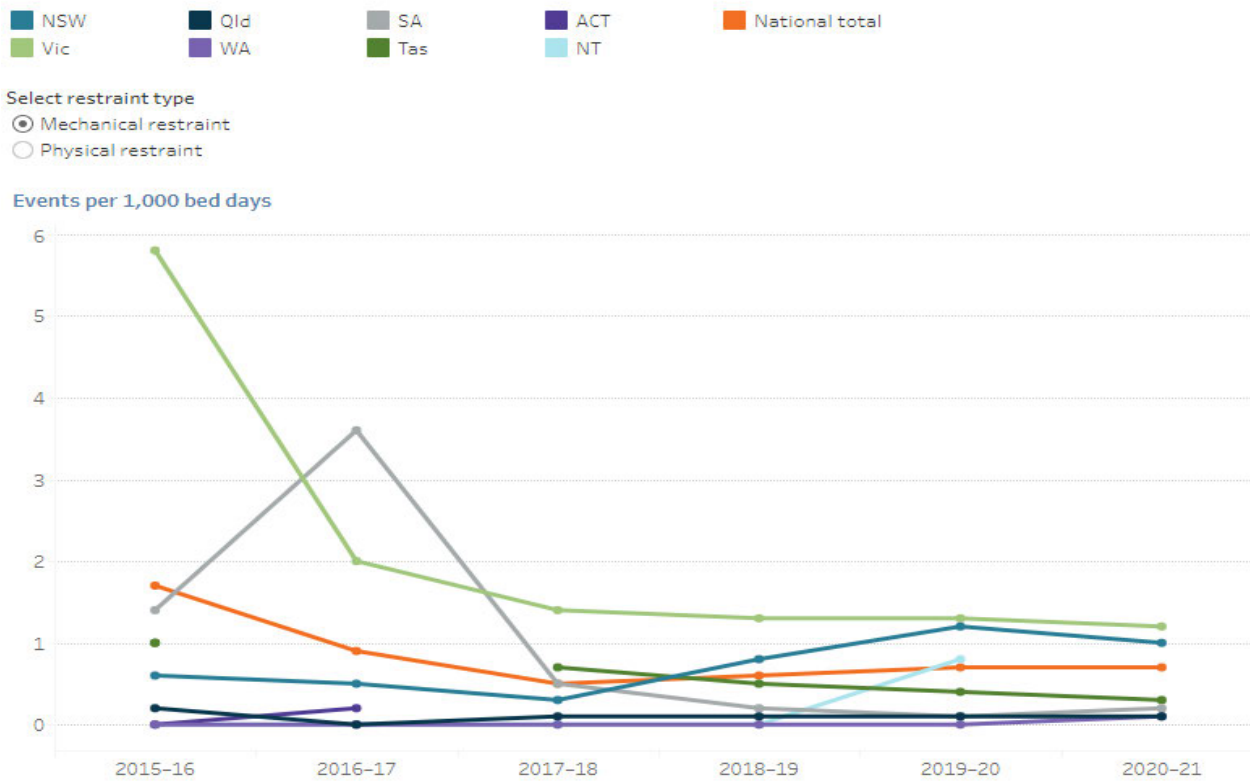


Source: Australian Institute of Health and Welfare, Mental Health Services in Australia, 2022, Web Report

Figure 6: Rates of seclusion in mental health services by states and territories 2008-21

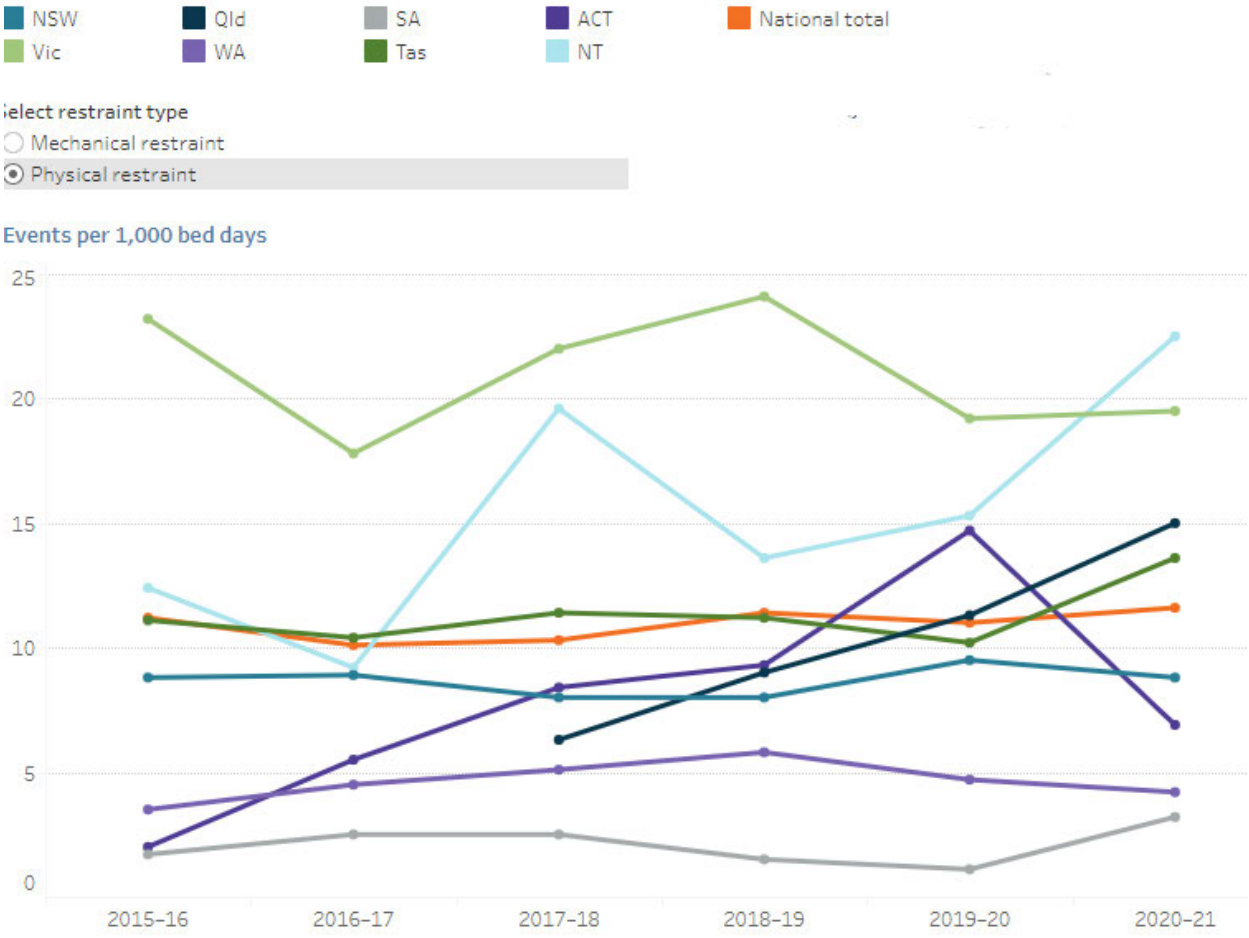
In relation to restraint, Figure 6, on the following page, indicates the rates of mechanical restraint events in mental health services by states and territories in the period 2015-16 to 2020-21. Figure 7, also on the following pages, indicates the rates of physical restraint events in mental health services by states and territories in the period 2015-16 to 2020-21. These figures suggest there has been a reduction at the national level in use of mechanical restraint events in mental health services. Indeed, use of mechanical restraint has more than halved in the last five years since data coverage began.[649] In contrast, use of physical restraint has remained largely stable at the national level over the past five years. During 2020-21 there were 19,690 physical restraint events and 1,108 mechanical restraint events.[650] We note that the *National Targets and Indicators for Mental Health Reform* sought a meaningful baseline measure for all forms of restraint by 2017, and then 90 per cent reduction on baseline by 2023.

We were unable to find any further data from the Australian Institute of Health and Welfare or elsewhere about other forms of restraint or the use of involuntary treatment orders.



Source: Australian Institute of Health and Welfare, Mental Health Services in Australia, 2022, Web Report

Figure 7: Rates of mechanical restraint events in mental health services by states and territories 2015-21



Source: Australian Institute of Health and Welfare, Mental Health Services in Australia, 2022, Web Report

Figure 8: Rates of physical restraint events in mental health services by states and territories 2015-21

In relation to disability service settings, the *Targeted Action Plan for Safety under the National Disability Strategy 2021-2023* also specifies some targets for achieving reduction and/or elimination of restrictive practices. These targets include:

1. Consistent national definitions and authorisation processes in place for the use of restrictive practices by 2023.
2. Best practice restrictive practice regulation implemented across the care and support sector, by 2024.
3. Reduction in the use of restrictive practices over time.[651]

The progress of Australian governments against these targets has not been published at this time.

5.1.2.2 An emphasis on positive behaviour support

Several of the frameworks or principles for reducing and/or eliminating restrictive practices settings emphasise a need to build a workforce skilled in positive behaviour support planning and implementation. For instance, in the context of education settings, the 2017 *Principles for Reduction and Elimination of Restraint and Seclusion in Victorian Government Schools,* Principle 8 states that:

> Any use of physical restraint or seclusion must trigger a review and, if appropriate, a revision of behavioural strategies currently in place to address behaviour that causes harm to self or others. If positive behaviour strategies are not in place, staff should develop them.[652]

Principle 10 further states that:

> Teachers and relevant school staff should be trained regularly on the appropriate use of effective alternatives to physical restraint and seclusion, such as positive behaviour support.[653]

In the context of disability services, both the 2016 *NDIS Quality and Safeguarding Framework*, 2020 *Regulated Restrictive Practices Guide* and the 2021 *Positive Behaviour Support Capability Framework,* emphasise the need to develop a 'skilled positive behaviour support workforce'.[654] The 2021 *Positive Behaviour Support Capability Framework* outlines the skills and capabilities considered to be 'core' to a behaviour support practitioner, as well as those skills and capabilities expected of a practitioner rated as 'proficient' or above. [655]

The effects of building a skilled, positive behaviour support workforce in disability service settings and educational settings in Australia have not been investigated at this time. There is also no indication at this time of when the 2021 *Positive Behaviour Support Capability Framework* will be evaluated. However, the NDIS Quality and Safeguards Commission provides some public reporting on elements of the *Positive Behaviour Support Capability Framework*. For instance, the 1 January to 31 March 2022 activity report of the NDIS Quality and Safeguards Commission indicates that as at 31 March 2022, 1,336 behaviour support practitioners had completed a self-assessment against the Positive Behaviour Support Capability Framework and had been deemed 'suitable'.[656]

In section 5.1.2.3 immediately below we consider the literature on workforce development, training and education in general. In section 5.3 of this chapter, we provide a detailed review of the research literature concerning the effectiveness of positive behaviour support more broadly.

5.1.2.3 An emphasis on workforce development, training and education

Several of the frameworks and principles outlined in Tables 2 to 6 refer to the necessity for workforce development, training and education. As outlined across Chapters 3 and 4 of this report, workplace and workforce concerns are core features within the ecological system of restrictive practices and are some of the key dynamics driving use of restrictive practices.

It therefore makes sense that many frameworks and principles designed to reduce and/or eliminate restrictive practices will include one or more features that attend to the development of the workforce.

As indicated above, in the context of disability service settings and education settings, this emphasis on workforce development primarily revolves around positive behaviour support training and education. Thus, for instance, the previously mentioned 2021 *Positive Behaviour Support Capability Framework,* produced by NDIS Quality and Safeguards Commission, was specifically designed to provide guidance in relation to maintaining and developing 'the existing workforce by providing a framework for capability development and career progression', and to 'outline expectations for supervision and continuing professional development within the behaviour support context' in the context of NDIS disability services.[657]

In mental health settings, many of the frameworks and principles emphasise staff training in recovery and trauma-informed practices. For instance, the 2013 Victorian *Framework for Reducing Restrictive Interventions* provides the following 'core practice principles' for developing a capable and skilled workforce where restrictive practices are used only as a last resort include:

- Reducing restrictive interventions requires an interdisciplinary partnership committed to sustained effort.
- Healthy teams are built on individual and collective skill sets.
- A skilled workforce is resourced and supported.
- Competence in, and commitment to, recovery-oriented practice and a focus on supported decision making and self-determination are key features of the interdisciplinary team.
- Roles are clear and accountable.
- There is recognition of trauma and its impact on people with a lived experience, carers and staff.
- The health service is a safe environment where governance arrangements support and enable open dialogue on the dignity of risk, best interests and duty of care.
- The environment values learning and authorises and fosters open disclosure.
- The organisation is committed to continuous learning and quality improvement.[658]

In health and other settings, there appears to be an emphasis on training members of the workforce to implement restraint safely.[659]

Again, the effects of workforce development, training and education in Australia as a result of these frameworks and principles has not been studied. We can, however, offer some broad observations about the effectiveness of workforce development, training and education in general.

As outlined in Chapter 4, section 4.2.1, some forms of staff training can produce counterintuitive and counterproductive effects. Indeed, as Chapter 4 detailed, across a range of settings, including community-based supported accommodation for people with disability, as well as a behavioural healthcare facility that serves people with intellectual, developmental and psychiatric disabilities, there has been an increase in the use of restrictive practices following training relating to how and when to use restrictive practices.[660] As explained in Chapter 4, while this seemingly illogical outcome of staff training has not been fully explored in the research literature, some studies suggest it may occur as a result of staff not 'acquir[ing] the skills taught in the workshop', or applying them 'incorrectly, indiscriminately or ineffectively', or believing that they have learned that 'they should use restraints more often to prevent injuries'.[661] Other studies suggest that for some staff, training can have little to no effect because they are committed to believing restrictive practices are necessary,[662] while other staff may find training has a reinforcing effect – that is, training focuses their attention on use of restrictive practices as an option in practice.[663]

Notably, there are some more positive findings in relation to training in trauma-informed practices. Indeed, a 2018 evaluation of a program model for minimising restraint and seclusion found that when staff were trained in trauma-informed mindsets that ask employees to 'reassure clients, ask questions instead of making assumptions, be flexible, let go of the upper hand, and treat others with kindness and respect', this results in '99% decrease in restraint frequency, a 97% decrease in staff injury from a restraint, a 64% decrease in client-induced staff injury, and an increase in client goal mastery 133%'.[664] We provide a detailed case study of a trauma-informed approach to reducing and/eliminating restrictive practices in the next section on international approaches, to which we turn now.

5.2 International approaches to reduction and elimination

Australia is not alone in its attempts to reduce or eliminate restrictive practices. In 2020, Gooding, McSherry and Roper published a scoping review of English-language studies concerning the prevention and reduction of 'coercion' in mental health services around the world. This review found that 'overwhelmingly, governments, service providers or community advocates have been effective – to varying degrees – when taking steps to prevent or reduce coercive practices',[665] with some approaches showing greater success than others. In this chapter we focus attention on approaches developed in UK and US that have shown some success in preventing or reducing restrictive practices. We focus on these two jurisdictions because their approaches form the basis of many of the current reduction and elimination approaches in countries such as Australia and New Zealand.

Table 7 on the following pages provides a summary of the core strategies and principles of UK and US approaches to reducing or eliminating restrictive practices. As Table 7 indicates, some of the 'high level' frameworks, principles and approaches used to guide international approaches have been evaluated or studied for their effect. Following the presentation of Table 7, we provide detailed case studies of three of the international approaches to reducing

restrictive practices that have been studied, and which have had some success in reducing restrictive practices. These three examples have been adopted by several countries over the years, including, in two of the cases, Australia.

Importantly, as indicated in the introduction to this Chapter, all three of the approaches we consider here were developed for, and implemented within, the context of mental health settings. We were unable to identify any national or international examples of approaches to reduction and/or elimination that were developed for disability service settings and have been evaluated for effectiveness. As we outline in section 5.2.1-5.2.3 below, some of the case examples from mental health contexts have been adopted in other settings, including disability service settings and education settings. This transplantation has produced varying success.

Table 7: US and UK strategies, frameworks, policies or models for reducing and/or eliminating restrictive practices

Title	Year	Jurisdiction	Setting	Core strategies/principles	Effect studied?
15 Principles	2012	United States	Education	The 15 principles proposed are: 1. Every effort should be made to prevent the need for the use of restraint and for the use of seclusion. 2. Schools should never use mechanical restraints to restrict a child's freedom of movement, and schools should never use a drug or medication to control behaviour or restrict freedom of movement (except as authorized by a licensed physician or other qualified health professional). 3. Physical restraint or seclusion should not be used except in situations where the child's poses imminent danger of serious physical harm to self or others and other interventions are ineffective and should be discontinued as soon as imminent danger of serious physical harm to self or others has dissipated. 4. Policies restricting the use of restraint and seclusion should apply to all children, not just children with disabilities. 5. Any behavioural intervention must be consistent with the child's rights to be treated with dignity and to be free from abuse. 6. Restraint or seclusion should never be used as punishment or discipline (e.g., placing in seclusion for out-of-seat behaviour), as a means of coercion or retaliation, or as a convenience. 7. Restraint or seclusion should never be used in a manner that restricts a child's breathing or harms the child. 8. The use of restraint or seclusion, particularly when there is repeated use for an individual child, multiple uses within the same classroom, or multiple uses by the same individual, should trigger a review and, if appropriate, revision of strategies currently in place to address dangerous behaviour; if positive behavioural strategies are not in place, staff should consider developing them.	No

Title	Year	Jurisdiction	Setting	Core strategies/principles	Effect studied?
				9. Behavioural strategies to address dangerous behaviour that results in the use of restraint or seclusion should address the underlying cause or purpose of the dangerous behaviour. 10. Teachers and other personnel should be trained regularly on the appropriate use of effective alternatives to physical restraint and seclusion, such as positive behavioural interventions and supports and, only for cases involving imminent danger of serious physical harm, on the safe use of physical restraint and seclusion. 11. Every instance in which restraint or seclusion is used should be carefully and continuously and visually monitored to ensure the appropriateness of its use and safety of the child, other children, teachers, and other personnel. 12. Parents should be informed of the policies on restraint and seclusion at their child's school or other educational setting, as well as applicable Federal, State, or local laws. 13. Parents should be notified as soon as possible following each instance in which restraint or seclusion is used with their child. 14. Policies regarding the use of restraint and seclusion should be reviewed regularly and updated as appropriate. 15. Policies regarding the use of restraint and seclusion should provide that each incident involving the use of restraint or seclusion should be documented in writing and provide for the collection of specific data that would enable teachers, staff, and other personnel to understand and implement the preceding principles.[666]	

Title	Year	Jurisdiction	Setting	Core strategies/principles	Effect studied?
No Force First	2006	United States	Mental Health Services	Fundamentally, the 'No Force First' project requires that any form of force or coercion is only ever used as a last resort. To achieve this objective organisations need to take a whole-of-organisation approach that is tailored to their own circumstances but this should include:[667] 1. Changing mission and policy to reflect a commitment to recovery, including force and coercion as a recognised barrier. This should be available to the public and patients. 2. Hiring those with lived experience in meaningful employment positions and embracing the value of peer support. 3. Efforts to change the existing staff culture so that it embodies the commitment to recovery and no force first. This will require efforts to engage with staff to understand their concerns and potential barriers to reducing force and coercion. This will also include relevant training to provide staff the alternative skills necessary. 4. Update hiring processes so that identify people who will be compatible with a commitment to No Force First. 5. Developing compatible procedures. Policies that detail when force and coercion can be used are clear, limited and avoid subjective assessment were possible. Policies should be introduced that detail the follow up procedures when force or coercion is used, including debriefing and other forms of post-incident support. It should also include an opportunity for staff member learning and development. 6. Strategies and initiatives to develop trusting relationships between staff and patients to enable their cooperation in the recovery process.	Yes

Title	Year	Jurisdiction	Setting	Core strategies/principles	Effect studied?
Restraint Reduction Network Training Standards	2019	United Kingdom	Education, Health and Social Care	A training accreditation process that applies a human rights framework to the use of restrictive practices.	No
Six Core Strategies	2006	United States	Mental Health Services	The Six Core Strategies can be summarised as follows:[668] 1. Leadership towards organisational change: 'To reduce the use of seclusion and restraint by defining and articulating a mission, philosophy of care, guiding values, and assuring for the development of a S/R reduction plan and plan implementation'. 2. Use of data to inform practice: 'To reduce the use of S/R by using data in an empirical, non-punitive, manner'. 3. Workforce development: 'To create a treatment environment whose policy, procedures, and practices are grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health services and the experiences of our staff.' 4. Use of S/R prevention tools: 'To reduce the use of S/R through the use of a variety of tools and assessments that are integrated into each individual consumer's treatment stay'. 5. Consumer roles in inpatient settings: 'To assure for the full and formal inclusion of consumers or people in recovery in a variety of roles in the organization to assist in the reduction of S/R'. 6. Debriefing techniques: 'To reduce the use of S/R through knowledge gained from a rigorous analysis of S/R events and the use of this knowledge to inform policy, procedures, and practices to avoid repeats in the future'.	Yes

Title	Year	Jurisdiction	Setting	Core strategies/principles	Effect studied?
Reducing Restrictive Practices Frame-work	2021	Wales, United Kingdom	Education, Health, and Social Care	The framework has three main focuses:[669] 1. Preventing the necessity for restrictive practice through the development of reduction strategies and through the promotion of a human rights approach. 2. Working with individuals through person centred planning to meet individual needs in a way that actively reduces the likelihood of situations arising where restrictive practices are used as a last resort. 3. Having measures in place so that when situations arise where restrictive practice are used as a last resort, to prevent harm to the individual or others, there is prior planning and training in place to secure the safety of all concern Under each of these focuses there are various suggested steps including relevant policies, procedures, staff training, data collection, and strong executive leadership.	No
Northern Ireland Regional Policy on the use of Restrictive Practices in Health and Social Care Settings	2021	Northern Ireland, United Kingdom	Health and Social Care	The policy is designed around seven core standards that organisations were expected to comply with. These standards are: 1. All organisations must use the standard definitions to identify all interventions 2. All local policies and practices must embed use of the Three Steps to Positive Practice Framework when considering and reviewing the use of restrictive interventions 3. Proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people must be the basis on which to build agreed care and treatment plans 4. Organisational strategies and related policies for minimising the use of restrictive interventions must follow a minimum content format	No

Title	Year	Jurisdiction	Setting	Core strategies/principles	Effect studied?
				5. Effective and person-centred communication must be central to care and treatment planning 6. Roles and responsibilities are defined in terms of monitoring, reporting and governance 7. Any use of seclusion as a last resort intervention must follow the regional operating procedures.[670]	
Reducing the Need for Restraint and Restrictive Inter-vention	2019	United Kingdom	Education, Health and Social Care that provide services to Children and Young People	The advice document is primarily based around a series of key actions that organisations should undergo to facilitate making steps to reduce the use of restrictive practices. These key actions can be summarised as:[671] 1. Have a clear policy for meeting children and young people's individual needs and promoting positive relationships and behaviour. This should include measures for understanding children and young people's needs and the causes of behaviour, anticipating situations that may cause distress and taking steps to address them, assessing, managing and reducing risk, thereby reducing the likelihood of restraint. 2. Know the law and relevant guidance and have clear governance and accountability arrangements for supporting children and young people whose behaviour challenges and for any use of restraint, including arrangements for working across settings and services. 3. Involve children, young people and their parents/carers as appropriate in decisions relating to behaviour and use of restraint, and in discussing restrictive interventions and their impact, including through the development of behaviour support plans. 4. Use evidence-based approaches to promoting positive behaviour and supporting individual children and young people whose behaviour challenges.	No

Title	Year	Jurisdiction	Setting	Core strategies/principles	Effect studied?
				5. Have sound measures in place for training and developing staff, including training in understanding children and young people whose behaviour challenges, developing the skills to respond to their needs and understanding when expert help is required. 6. Have a system in place for continually improving assessment and management of risk. 7. Have a system for recording and reporting incidents (distinguishing between planned and unplanned interventions) which enables children and young people who have been restrained to express their feelings about their experience as soon as is practicable, to add their views and comments to the record of restraint and offers them the opportunity to access advocacy support to help them with this. 8. Have a system in place for reviewing how restraint is used in individual cases and patterns or trends in its use to inform changes in approach where necessary. 9. Recognise the impact of environment on individuals, and critically review their environment and practices, better to support children and young people and the reduction of restraint in line with best practice.	
Safewards	2014	United Kingdom	Mental Health Services	The model attempts to provide a range of evidence-based interventions that can be used to address various flashpoints to reduce or eradicate the conflict originating factors. The ten interventions suggested are: 1. Know each other – Collecting and using personal information to build a relationship with patients that extends beyond the health needs. 2. Clear mutual expectations – Have clear and consistent expectations for both staff and service user behaviour. 3. Mutual help meeting – Cultivate a positive supportive environment amongst patients on the ward. This includes an understanding of individual patients' needs or triggers and communal support.	Yes

Title	Year	Jurisdiction	Setting	Core strategies/principles	Effect studied?
				4. Calm down methods – Having in place training to assist staff to identify signs of increasing agitation. It also includes having in place a range of different tools to assist the person to calm down. These tools should include a range of non-medication tools that should be used first. 5. Bad news mitigation – This requires staff to be able to recognise the kind of information that may disappoint/stress a service user and then provide the appropriate supports to prevent the giving of that information to a service user becoming a flashpoint. 6. Soft words – Emphasises the important from staff to avoid confrontations and work collaboratively with service users. Soft words expects staff to deliver limit setting messages to service users in as non-aggressive or confrontational way as possible. 7. Talk down – Expects that service providers have a range of de-escalation tools that allow staff to talk to the agitated service user to help them calm down. 8. Reassurance – This intervention focuses on the potential for one point of conflict spreading to other service users by causing them anxiety. In essence, there is a need to not only focus on the agitated person but to allay the concerns of others around them. 9. Discharge messages – Discharge measures should be framed around hope, a positive future, and authoritative messages about the benefit and purpose of the admission. Assisting service users to frame their time at the mental heath service in a positive way has flow on benefits to other residents, and if the person does return helps make that process easier. 10. Positive words – Interactions between staff, particularly handovers, should emphasise something positive or constructive about the service user. This helps to prevent negative connotations with particular service users and assists staff to build on positive events with the service user.[672]	

5.2.1 The 'No Force First Project': England

In 2013, the Mersey Care Foundation Trust, a large NHS trust in North West England, designed and implemented the 'No Force First' project. The project was based upon initiatives to reduce the use of restrictive practices that were initially used in inpatient mental health units in the United States.[673] The No Force First project is based around a shift in the 'culture of care within our services and transforming the care narrative from "containment" to "recovery"'.[674]

The No Force First project is grounded in the ideals of 'recovery-oriented services'. The project works with the proposition that effective recovery for people receiving these services requires enabling people's 'choice, self-determination, and personhood.'[675] Within this context, any form of force or coercion is understood to ultimately undermine the person's recovery. This means that while the primary focus of the No Force First project was the reduction of restrictive practices, the No Force First project was also intended to apply to other coercive practices that may not be legally defined as restrictive practices at this time, but which undermine choice, self-determination and personhood.

Fundamentally, the No Force First project requires that any form of force or coercion is only ever used as a last resort.[676] To achieve this objective, organisations are instructed to take a whole-of-organisation approach, tailored to their own circumstances, but which focuses on:

1. Changing mission and policy to reflect a commitment to recovery, including force and coercion as a recognised barrier. This should be available to the public and patients.
2. Hiring those with lived experience in meaningful employment positions and embracing the value of peer support.
3. Efforts to change the existing staff culture so that it embodies the commitment to recovery and no force first. This will require efforts to engage with staff to understand their concerns and potential barriers to reducing force and coercion. This will also include relevant training to provide staff the alternative skills necessary.
4. Update hiring processes so that identify people who will be compatible with a commitment to No Force First.
5. Developing compatible procedures. Policies that detail when force and coercion can be used are clear, limited and avoid subjective assessment were possible. Policies should be introduced that detail the follow up procedures when force or coercion is used, including debriefing and other forms of post-incident support. It should also include an opportunity for staff member learning and development.
6. Strategies and initiatives to develop trusting relationships between staff and patients to enable their cooperation in the recovery process.[677]

The No Force First project resulted in significant initial reduction in the use of restrictive practices. There was a 50 per cent reduction in the use of physical and chemical restraint on the pilot wards in the first year.[678] After 3 years of practice – once the No Force First approach was implemented across all wards – there was a 37 per cent reduction in the use of restraint and a 46 per cent reduction in the assault of staff.[679] These reductions have been associated with significant financial savings.[680]

Notably, a 2012 examination of the implementation of the No Force First approach in a crisis centre considered the impact of the approach on chemical restraint use specifically. The study sought to better understand if in the absence of seclusion and mechanical restraint practices, organisations will rely on chemical restraint practices to achieve the same objectives. Focusing on a crisis centre where seclusion and restraint practices were claimed to have been eliminated already, the study found that chemical restraint was used for 0.45 per cent of service users over a two-year period. This finding led the study to conclude that 'crisis services can be successfully provided by adopting recovery approaches that do not rely on seclusion and mechanical or chemical restraints.'[681]

Due to the success of the No Force First project, a range of other NHS trusts and other mental health and learning disability services from around the UK and Europe have implemented similar projects.[682] In the context of mental health and learning disability settings in the UK, a recent evaluation of the No Force First approach found 'a significant 17% reduction in incidence of physical restraint […] in addition to reductions in associated rates of harm sustained and episodes of aggression and violence'.[683] Of relevance to the research interests of the Disability Royal Commission in differences between settings, the evaluation found that there was a significantly higher prevalence of physical restraint and harm in forensic learning disability wards as compared to forensic mental health wards.[684] This difference was recorded both pre- and post-introduction of a No Force First informed organisational guide to reduce physical restraint.[685]

5.2.2 The 'Six Core Strategies to Reduce Seclusion and Restraint Use': USA

The 'Six Core Strategies to Reduce Seclusion and Restraint Use' is a high-level framework developed by the National Association of State Mental Health Program Directors (NASMHPD) in 2006.[686] The NASMPHD is a representative organisation of public mental health service commissioners/directors and their agencies. The NASMPHD represents all 50 states of the US, as well as 6 territories and Pacific jurisdictions, and the District of Columbia.

The Six Core Strategies is designed as a high-level set of key principles and initiatives to guide organisations attempting to reduce use of restrictive practices. The Six Core Strategies are framed so they can 'be applied flexibly to meet the needs of particular service settings, so that bespoke and context-appropriate solutions can be developed to meet the needs of local services and communities.'[687] As such, although the Six Core Strategies were developed to be used within mental health settings, they have been applied in other settings.[688]

The Six Core Strategies propose a trauma-informed approach to services, and can be summarised as follows:

1. Leadership towards organisational change: 'to reduce the use of seclusion and restraint by defining and articulating a mission, philosophy of care, guiding values, and assuring for the development of a S/R [seclusion/restraint] reduction plan and plan implementation.'[689]
2. Use of data to inform practice: 'to reduce the use of S/R by using data in an empirical, non-punitive, manner.'[690]
3. Workforce development: 'to create a treatment environment whose policy, procedures, and practices are grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health services and the experiences of our staff'.[691]
4. Use of seclusion and restraint prevention tools: 'to reduce the use of S/R through the use of a variety of tools and assessments that are integrated into each individual consumer's treatment stay.'[692]
5. Consumer roles in inpatient settings: 'to assure for the full and formal inclusion of consumers or people in recovery in a variety of roles in the organization to assist in the reduction of S/R.'[693]
6. Debriefing techniques: 'to reduce the use of S/R through knowledge gained from a rigorous analysis of S/R events and the use of this knowledge to inform policy, procedures, and practices to avoid repeats in the future.'[694]

The Six Core Strategies have been implemented, or recommended to be implemented, in a variety of jurisdictions including, New Zealand[695], the United Kingdom,[696] and Australia.[697]

The effectiveness of the Six Core Strategies has been studied in several settings and countries. For instance, a 2014 Canadian study in the context of a specialised mental health organisation found a decrease of 19.7 per cent in the total number of restraint incidents.[698] This decrease was primarily due to a 28.3 per cent decrease in seclusion incidents post the Strategies implementation.[699] Similarly, an adapted version of the Six Core Strategies in the UK led to an average reduction in restraint of 22 per cent in adult mental health wards.[700] In the US state of New York, a three-site study showed a decrease of between 62 per cent and 86 per cent in the number of incidents per 1,000 client-days.[701] A downward trend in use of restraint and seclusion was also found in the context of a child and adolescent psychiatric hospital in the US.[702] The Six Core Strategies have further been proposed as appropriate for use in the context of organisations working with people with acquired brain injury.[703]

Of relevance to this report, it has been noted that to create coercion- and violence-free environments there must be 'a major commitment by all staff over an extended period to fully understand and internalise the strategies involved and embrace the changes in facility culture'.[704]

5.2.2.1 Australia's adoption of the Six Core Strategies: The Safe in Care, Safe at Work Toolkit

In 2019 the Australian College of Mental Health Nurses, adapted the original Six Core Strategies framework, creating a *Safe in Care, Safe at Work Toolkit* that could be used in the Australian context.[705] While the *Toolkit* maintains the Six Core Strategies' emphasis on flexibility and tailoring the approach to a specific context, the *Toolkit* seeks to provide more nuanced guidance for organisations. To this end, the *Toolkit* provides service objectives under each strategy, which, when taken in conjunction, may enable an organisation to satisfy the ultimate strategy. For example, according to the *Toolkit*, Strategy One – leadership towards organisational change – could be achieved by asking:

1. Does the organisation and service mission/vision statement, philosophy, and core values reflect the intent of seclusion and restraint reduction initiatives?
2. Has the service developed a seclusion and restraint policy statement that includes beliefs to guide use that is congruent with mission, vision, values and recovery principles?
3. Has the service leadership developed an individualised serviced – based seclusion and restraint reduction action plan? Is this included in overall service strategic plans such as annual plans?
4. Has service leadership committed to create a collaborative, non-punitive environment, including: identifying and working through problems; communicating expectations to staff; being consistent in maintaining effort?
5. Are all staff aware of the role and responsibility of the general manager or service leader to direct seclusion and restraint reduction initiatives?
6. Has service leadership evaluated the impact of reducing seclusion and restraint on the whole environment?
7. Has service leadership set up a staff recognition project to reward individual staff, unit staff and seclusion and restraint champions for change for their work on and on – going basis?
8. Does the executive/senior leadership approved seclusion and restraint reduction plan delegate tasks and hold people accountable through routine reports and reviews?
9. Has service leadership addressed staff culture issues, training needs and attitudes?
10. Has service leadership reviewed the services plan for clinical treatment activities to ensure that active, daily, people-centred, effective treatment activities are available and offered to all people receiving services?
11. Has leadership ensured oversight accountability by watching and elevating the visibility of every event 24 hours a day, seven days per week?
12. Has service leadership ensured consumer inclusion, leadership and perspectives are part of all seclusion and restraint reduction plans, initiatives and evaluations?

13. Has service leadership ensured Aboriginal and Torres Strait Islander inclusion, leadership and perspectives are part of all seclusion and restraint production plans, initiatives and evaluations?

14. Has service leadership ensured family and carer inclusion and perspectives in seclusion and restraint reduction initiatives?[706]

The *Toolkit* further provides 'evaluative criteria' for assessing the effectiveness of the steps taken to achieve the core strategy. For example, in relation to the first core strategy, the *Toolkit* suggests the following criteria be met:

a. A clear vision for safety in care and safety at work is articulated and shared, resulting in inclusive and respectful environments for consumers, carers and mental health staff including the specific needs of Aboriginal and Torres Strait Islander people;

b. Site-specific safety plans that meet all relevant standards are developed, implemented, regularly reviewed and revised;

c. Staff, carer and consumer concerns, actual and potential safety issues or breaches to safety for consumers, carers and staff are anticipated, acknowledged and addressed in a non-punitive process; and

d. Successes are recognised and celebrated.[707]

The *Toolkit* has not been formally evaluated at the time of writing this report.

5.2.3 The 'Safewards Model': England

Safewards is a clinical model for the management of conflict in mental health settings.[708] The Model was originally developed in England as a tool to create a safer environment for both staff and patients. While the Safewards Model includes consideration of restrictive practices use, the model has a broader focus on understanding conflict, its causes, and staff responses to it.

Under the Safewards Model, conflict is believed to begin within an 'originating domain'. There are six identified originating domains: patient, community, patient characteristics, regulatory framework, staff team and physical environment.[709] Within these originating domains, there are then potential triggers for 'conflict'. According to the Model, these triggers, or 'flashpoints', are best understood as 'social and psychological situations arising out of features of the originating domains, signalling and proceeding imminent conflict behaviours.'[710] Conflicts themselves are then understood to be 'events that threaten staff and patient safety, such as self-harm, suicide, aggression, absconding.'[711] When such events arise, the Model proposes the next step is for staff to 'contain' them. Here, containment is understood to be the 'things staff do to prevent or reduce harm to staff and patients', this includes, but is not limited to, use of restrictive practices.[712] Importantly, in this Model, a containment measure, such as use of chemical restraint or seclusion is recognised as also acting as a potential 'flashpoint' – that is, as something which signals and proceeds imminent perceived conflict behaviours.

The Safewards Model goes beyond providing a framework to understand conflict on inpatient mental health wards. It attempts to provide a range of evidence-based interventions that can be used to address various 'flashpoints' to reduce or eliminate the factors contributing to the 'conflict'.[713] The ten interventions suggested by the Safewards Model include:

1. Know each other: collecting and using personal information to build a relationship with patients that extends beyond their health needs.[714]
2. Clear mutual expectations: Have clear and consistent expectations for both staff and service user behaviour.[715]
3. Mutual help meeting: Cultivate a positive supportive environment amongst patients on the ward. This includes an understanding of individual patients' needs or triggers and communal support.[716]
4. Calm down methods: Having in place training to assist staff to identify signs of increasing agitation. It also includes having in place a range of different tools to assist the person to calm down. These tools should include a range of non-medication tools that should be used first.[717]
5. Bad news mitigation: This requires staff to be able to recognise the kind of information that may disappoint/stress a service user and then provide the appropriate supports to prevent the giving of that information to a service user becoming a flashpoint.[718]
6. Soft words: Emphasises the importance of staff to avoid confrontations and work collaboratively with service users. Soft words expects staff to deliver limit setting messages to service users in as non-aggressive or confrontational way as possible.[719]
7. Talk down: Expects that service providers have a range of de-escalation tools that allow staff to talk to the agitated service user to help them calm down.[720]
8. Reassurance: This intervention focuses on the potential for one point of conflict spreading to other service users by causing them anxiety. In essence, there is a need to not only focus on the agitated person but to allay the concerns of others around them.[721]
9. Discharge messages – Discharge measures should be framed around hope, a positive future, and authoritative messages about the benefit and purpose of the admission. Assisting service users to frame their time at the mental health service in a positive way has flow on benefits to other residents, and if the person does return helps make that process easier.[722]
10. Positive words – Interactions between staff, particularly handovers, should emphasise something positive or constructive about the service user. This helps to prevent negative connotations with particular service users and assists staff to build on positive events with the service user.[723]

The Safewards Model has shown some positive effects in the context of general mental health settings. For instance, a pragmatic cluster randomised controlled trial with psychiatric

15 hospitals and 31 wards saw a 15 per cent reduction in 'conflict events', with the rate of containment reduced by 26.4 per cent after implementation of the Model.[724] Similarly, an interrupted time-series analysis of the Safewards Model in Southern Denmark for the period of 2012 to 2017 found a 2 per cent decrease in coercive measures per quarter, and an 11 per cent decrease in forced sedation per quarter.[725] Use of mechanical restraint was unaffected by the implementation of the Safewards Model in Southern Denmark.[726]

However, a 2022 systematic review of the effectiveness of the Safewards Model in practice concluded that while the Model shows some effect in reducing conflict and containment in general mental health inpatient services, it is unclear if these benefits extend beyond these specific settings.[727] Indeed, a study of the Safewards Model intervention on rates of conflict and containment in six wards of a forensic medium secure mental health service showed no significant benefit.[728]

There are also other limitations with the research literature surrounding the Safewards Model. For instance, it has been found that many studies of the Model are descriptive, based on single conflict or containment outcomes, or not grounded in theory.[729] Moreover, evaluations and studies of the Safewards Model have produced mixed results, including both between wards and within wards.[730] Consistent with some of the findings in Chapter 4 of this report on training, some studies suggest that the mixed results of the Safewards Model are influenced by both inadequate training and education of staff, as well as poor staff adherence and acceptance of the Model.[731]

5.2.3.1 Australia's adoption of the Safewards Model

Despite the above-described limitations with the Safewards Model, the Model has been adapted and implemented in a range of different jurisdictions around the world, including in the Australian states of Queensland, New South Wales and Victoria.

In Queensland, a study was undertaken into nursing staff perceptions of the factors impacting the implementation of the Safewards Model at three acute inpatient wards. Like the findings presented above in the international context, the Queensland study concluded that staff engagement was a major factor for success, with some nurses expressing resistance to change. Consistent with the findings presented in Chapter 4, nursing staff's resistance to change appeared to stem from the belief that they already know what is best in practice, and any change would undermine or question this knowledge.[732] Some staff were also shown to be reluctant to change due to a perception that any perceived aggression was the result of some 'internal' patient factor, and not those factors identified by the Model.[733]

The New South Wales study focused on the implementation of the Safewards package in one large metropolitan local health district in Sydney. The study was not controlled, nor randomised. The study determined that implementation of the Safewards package resulted in a 23 per cent reduction in overall conflict and a 12 per cent reduction in containment.[734]

The Victorian trial of the Safewards Model was evaluated for its impacts on use of seclusion, among other effects. The evaluation did not consider other forms of restrictive practices beyond seclusion. Evaluations of the Victorian trial found that there was no reduction in the use of seclusion during the trial period,[735] although there was a 36 per cent reduction in the rate of seclusion from the pre-trial period to follow up period (one year later).[736] Ultimately the evaluation report concluded that 'Safewards was not robustly associated with reduction of seclusion, as the chosen measure of containment, but there are indications of a seclusion reduction trend across the Safewards wards, by the follow up time-point.'[737]

5.2.4 Common features of international approaches to reduction and/or elimination

As demonstrated, the case studies provided above have each been studied, and have each had some success in reducing restrictive practices. All three of these examples of evaluated practices were developed for, and implemented within, the context of mental health settings. As outlined, some of the case examples have been adopted in other settings, including disability service settings and education settings, with varying success. In considering the three case studies together, there are two common features that can be observed.

5.2.4.1 An emphasis on leadership towards organisational change

Common to at least two of the three case studies outlined above is an emphasis on leadership towards organisational change. The 'No Force First' project recommends 'changing mission and policy to reflect a commitment to recovery, including force and coercion as a recognised barrier'.[738] Similarly, the 'Six Core Strategies' outline 14 questions for organisations to address to ensure that the organisation will enact leadership towards organisational change.

As outlined in Chapter 4 of this report, organisational cultures of risk and blame have been identified as part of the workplace dynamics driving restrictive practices. As also explained in Chapter 4, several studies identify strong leadership towards organisational change as important for reducing and/or eliminating restrictive practices.[739] Indeed, it has been proposed that unless explicit declarations against use of restrictive practices are made at the local, national, or international level, staff may continue to rely on restrictive practices in their work, and continue to assume that alternative methods of response are not possible.[740] Accordingly, it makes sense that both the 'No Force First' project and the 'Six Core Strategies' emphasise leadership towards organisational change as part of their proposed actions for reducing and/or eliminating restrictive practices.

5.2.4.1 An emphasis on fostering better relationship dynamics in service settings

The second feature common to the above case studies of international approaches are suggested actions or interventions for fostering better relationship dynamics between staff

and people with disability. In the case of the 'No Force First' project, for instance, there is direction to develop 'strategies and initiatives to develop trusting relationships between staff and patients to enable their cooperation in the recovery process.'[741] Here we note that in the 'No Force First' project, effective recovery is said to require services that enable people's 'choice, self-determination, and personhood.'[742] Likewise, the 'Six Core Strategies' emphasises recovery-oriented and trauma-informed approaches to service delivery, which includes creating environments that 'are less likely to be coercive or conflictual' by ensuring that they are based on principles such as 'person-centred care, choice, respect, dignity, partnerships, self-management, and full inclusion'.[743]

The Safewards Model also focuses on actions or interventions for fostering better relationship dynamics between staff and people with disability. Indeed, all ten of the evidence-based interventions which are proposed for reducing restrictive practices are relationships-focused. While evaluations of the Safewards Model do not consistently find the Model effective in reducing restrictive practices, we note that in the case of the Victorian evaluation, 'more than half [51%] of consumers said they 'usually' or 'always' felt safer and more positive on the ward, since Safewards was introduced'.[744] Of relevance to the findings presented in Chapters 2 and 3 of this report, when looking closer at the qualitative data captured about consumer experiences, it is interesting to note that those people who felt safer and more positive since Safewards was introduced appear to link these associations to experiences where they were being listened to and attended to when distressed (i.e. not abandoned), and where there are clear, mutual expectations of staff and consumers (i.e. no 'games' being played).[745]

5.3 Current approaches for operationalising reduction and/or elimination in Australia

In the previous two sections of the chapter, we outlined the 'high-level' frameworks and principles for reducing and/or eliminating restrictive practices that have been proposed in Australia and elsewhere. We also provided detailed overviews of three international approaches to reduction and elimination that have shown some success. In so doing, w e began to address both the second and fourth sets of questions set out by the Disability Royal Commission for this project.

In this section of the chapter, we return to the Australian context and explore how the 'high-level' frameworks and principles for reducing and/or eliminating restrictive practices in Australia outlined in section 5.1.1 have been operationalised. To do this, we focus our attention on the ways that the 2014 *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* has been operationalised through the establishment and operation of the NDIS Quality and Safeguards Commission and the NDIS Quality and Safeguards Commission's Quality and Safeguarding Framework. The NDIS Quality and Safeguards Commission is an independent agency charged with improving the quality and safety of NDIS supports and services. The NDIS Quality and

Safeguards Commission's Quality and Safeguarding Framework extends the work begun by the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector*.

We focus our attention here, on the establishment and operation of the NDIS Quality and Safeguards Commission and its Framework for two reasons. First, the NDIS Quality and Safeguards Commission is expressly responsible for regulating and monitoring the 'authorised' and 'unauthorised' use of restrictive practices in the context of NDIS-funded service provision. This focus on regulation, monitoring and authorisation of restrictive practices within the NDIS are presented as part of the core ways by which the aim of reducing and eliminating such practices are being addressed in Australia at this time.[746]

Second, while the authority of the NDIS Quality and Safeguards Commission is restricted to the disability service sector, and specifically, to the NDIS service sector, two of the core activities of the NDIS Quality and Safeguards Commission in relation to reducing and eliminating restrictive practices on the ground – positive behaviour support and the enforcement of behaviour support plans – already operate within some of the other services sectors where people with disability are present, or are being adopted in these sectors. In these ways, the lessons drawn from our consideration of the activities of the NDIS Quality and Safeguards Commission in relation to reducing and eliminating restrictive practices may hold implications for a range of service systems with which people with disability engage.

Our consideration of the current operationalisation of the 2014 *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* takes place across three sub-sections. These sub-sections are reflective of the three core activities outlined above: regulation and monitoring; authorisation; and positive behaviour support. Notably, in attending to positive behaviour support in this section of the chapter, the report addresses the third set of research questions set out by the Disability Royal Commission for this project: is positive behaviour support effective in reducing and eliminating the use of restrictive practices? Is it more effective in relation to certain types of disabilities, certain restrictive practices, or certain settings?

5.3.1 Regulation and monitoring restrictive practices

As outlined in the Introduction Chapter to this report, currently in Australia, only specific forms of restrictive practices in the disability service sector are said to be 'regulated'. These forms of restrictive practices are chemical restraint, mechanical restraint, physical restraint, environmental restraint, and seclusion. The regulation of these forms of restrictive practices are the responsibility of the NDIS Quality and Safeguards Commission, while the authorisation of these practices remains the responsibility of the state or territory. In practice this means that registered NDIS service providers who intend to use restrictive practices against people with disability must: (a) develop a NDIS behaviour support plan, (b) seek and gain authorisation from the relevant authority in their state or territory; and (c) comply with ongoing reporting

requirements to the NDIS Quality and Safeguards Commission. If a service provider deviates from this process – for example, by not seeking approval for using restrictive practices against a person with disability; by using restrictive practices in a way that does not accord with what was outlined in an approved behaviour support plan; or by failing to meet the reporting requirements of the NDIS Quality and Safeguards Commission – then their use of restrictive practices against people with disability is considered to be 'unauthorised', and these unauthorised uses of restrictive practices are classified as 'reportable incidents'.[747] The NDIS Quality and Safeguards Commission has responsibilities for monitoring reportable incidents, which, in addition to unauthorised restrictive practices, include the death, serious injury, abuse or neglect of a person with disability, as well as unlawful sexual or physical contact with, and sexual misconduct committed against a person with disability.[748]

One of the stated goals of the NDIS Quality and Safeguards Commission is to 'reduce unauthorised use of restrictive practices, which currently make up 90% of notified reportable incidents'.[749] To achieve this goal, the NDIS Quality and Safeguards Commission is undertaking activities that are said to ensure that all unauthorised uses of restrictive practices are 'instead authorised, according to state or territory requirements, and used in accordance with a behaviour support plan, safeguards participants in the supports they receive'.[750] In section 5.3.2 we return to engage further with the concept of 'authorised' uses of restrictive practices in Australia, and in section 5.3.3 we consider the evidence surrounding positive behaviour support and behaviour support planning. For now, in this sub-section of the chapter, we provide two short points of note about the NDIS Quality and Safeguards Commission's approach to *unauthorised* uses of restrictive practices.

First, we note that to date, the NDIS Quality and Safeguards Commission has shown *no success* in reducing the unauthorised uses of restrictive practices against people with disability. Indeed, during the one-year period of 1 July 2020 to 30 June 2021, unauthorised uses of restrictive practices were shown to have increased on a month-to-month basis, with the NDIS Quality and Safeguards Commission indicating that during this one-year period, 7,862 people with disability had been subjected to a total of 1,032,064 unauthorised uses of restrictive practices.[751]

Second, it is necessary to clarify, even if the NDIS Quality and Safeguards Commission prove successful in reducing the unauthorised uses of restrictive practices against people with disability in future years, the 'reduction' that would be observed would likely be misattributed. As both the *Activity Report* and the *NDIS Quality and Safeguards Commission 2020-2021 Annual Report* make clear, the primary way that the NDIS Quality and Safeguards Commission intends to reduce unauthorised uses of restrictive practices is by transforming these unauthorised uses – through compliance activities – into authorised uses of restrictive practices, primarily, through the completion of a behaviour support plan.[752] In other words, it is plausible that the amount of restrictive practices used against people with disability in future years will not be reduced through this strategy, with the only thing that changes during this period being the re-categorisation of these restrictive practices from 'unauthorised' to 'authorised'.

We turn now to consider some of the human rights implications associated with taking an 'authorisation approach' to the regulation and proposed reduction of restrictive practices.

5.3.2 Authorisation of restrictive practices and the legitimised use of force

As indicated above, during the one-year period of 1 July 2020 to 30 June 2021, 7,862 people with disability had been subjected to a total of 1,032,064 unauthorised uses of restrictive practices.[753] During this same time period, 10,109 people with disability were also subject to an undisclosed number of 'authorised' uses of restrictive practices.[754] Both the use of restrictive practices in general, and recent focus on 'authorised' and 'unauthorised' forms, pose a number of conceptual problems in relation to the legitimate or authorised use of force and its relationship to 'the rule of law'. This section explores some of the broad issues which the use of restrictive practices raises in relation to the rule of law and the discriminatory use of force against people with disability.

The concept of the rule of law might be understood as 'the antithesis of the exercise of arbitrary power,' in that the law consistently and accountably governs use of force, rather than the preferences of private individuals.[755] The commonly cited British jurist, A.V. Dicey, summarised the rule of law as comprising a combination of an absence of arbitrary power, universal application of law (i.e., nobody is above the law), and availability of individual rights.[756]

Rule of law is a fundamental concept for the rights of people with disability, since so many forms of violence, discrimination and exclusion experienced by people with disability constitute violations of the rule of law. This is because, people with disability have been subject to arbitrary power and violence and have been systematically exempted from the rights and protections that would otherwise apply to other individuals. As discussed in Chapter 4, an example of an exclusion from the expectations of the rule of law would be the *parens patriae* jurisdiction, or related guardianship and mental health legislation, which provide a mechanism for the consent on behalf of an individual to be given by select third parties.

Articles 12 and 13 of the CPRD articulate the principles that follow from applying the rule of law consistently to the treatment of people with disability. Central to these articles is the obligation to support the exercise of legal capacity. However if the will and preferences of the person with disability cannot be immediately ascertained, the 'best interpretation and will and preferences' must be used in a way that is 'free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body.'[757] In other words, in a general sense, the rule of law must govern the use of any exception to the obligation to ensure equal recognition before the law and legal capacity. Further, compliance with the CRPD obligations represents one way in which States parties can ensure that the rule of law prevails in relation to the treatment of people with disability.[758]

A pillar of the rule or law within liberal conceptions of government – such as that advanced by Thomas Hobbes or Jean-Jacques Rousseau– is that the State has a monopoly on violence.[759] This means during peacetime, violence can only be used in ways authorised by the State. Compliance with this ensures conformity with the rule of law, since any use of violence, either by the State or by non-State actors, must be legally authorised by the State through laws that have been passed in accordance with constitutional processes. Given this context, use of force should be authorised by the law, carried out by trained personnel accountable to the State, and subject to review processes to ensure accountability for the exercise of force. Further, the State has an obligation to prevent and hold accountable unauthorised uses of violence.

The police are the most prominent example of legitimate State agents of violence. In theory, the police satisfy the above criteria of being authorised by the State (and marked as such with the uniform), and subject to review for their actions. The police have the capacity to carry out a range of violent acts, including in some circumstances, the use of lethal force.[760] Relevant to this report, the police effectively have a right to make use of forms of restriction and restraint as part of the police function.[761] However, these powers are subject to review and limits. For example, in NSW, complaints relating to the excessive use of force can be made to the NSW Police or potentially the independent Law Enforcement Conduct Commission, while civil or criminal proceedings may be brought before the courts. Further, international human rights principles provide fundamental limits to the actions of the police. For example, Australia's obligations under the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment stipulate that interrogations should not involve torture and ill treatment. Australia's obligations under Article 9 of the International Covenant on Civil and Political Rights mean that police are not allowed to arbitrarily detain individuals. While police are perhaps the most prominent agents of legitimised State violence, they are not the only individuals who are authorised to use force. For example, correctional officers in prisons in NSW have had powers conferred on them to use force 'as a last resort to control or restrain inmates and other persons' in response to 'risk of harm.'[762] The use of force, and particularly the power to use restraint, was reviewed in the context of the 2016 Royal Commission into the Protection and Detention of Children in the Northern Territory. Information on this inquiry and its recommendations on the use of restraints in the context of child detention is included below in Case Example 1.

While the above implies that the State formally authorises and delegates all uses of force, this does not mean that under the law only individuals such as the police have a right to use violence. The law grants private individuals an exclusion of criminal responsibility in the use of reasonable force in self-defence.[763] Individuals may also exercise the limited power to make a "citizen's arrest"[764] However, it is important to note that these powers differ in extent from those formally granted to the police, in that the police are empowered to use force not just in the context of making an arrest but when exercising a function under legislation provided the force 'is reasonably necessary to exercise the function.'[765]

There are examples of police-like delegations of power to others– such as transit officers – who may have powers to apply sanctions such as fines and to use reasonable force, though notably in some jurisdictions, such as NSW, these positions have more recently been replaced with police officers.[766] In this context, there has been much scholarship and public concern in relation to the growth in private security firms. [767] Jurisdictions have created laws which regulate the licensing and training of private security personnel.[768] However notably, 'there is very little in Australian legislation, and even less in the common law, that permits security guards, even licensed guards, to wield specific powers.'[769]

Case Example 1: The Royal Commission into the Protection and Detention of Children in the Northern Territory and Recommendations on the Use of Restraint.

The Royal Commission into the Protection and Detention of Children in the Northern Territory was established in 2016. The Royal Commission examined the treatment of children in detention in the Northern Territory, and in that context, examined the use of force, including the use of physical restraint. The Royal Commission noted that within contemporary societies there are a limited range of situations where the use of force can be legally authorised.[770] This includes the use of force by law enforcement agencies and within the 'secure environment of a prison or detention centre.'[771] However, the Royal Commission noted that the use of force within closed settings, by nature of these settings, required detailed regulation: 'in these institutions, being closed, it is of paramount importance that the power be strictly described and circumscribed'.[772] The Royal Commission further stated that 'statutory clarification is desirable,' and that 'limitations upon the use of force be consistent, easily understood and not easily sidestepped'.[773]

Examining restraint in the context of child detention, the Royal Commission defined a restraint device as 'any device which is designed to immobilise a child or restrict their freedom of movement'.[774] In the face of significant utilisation of restraint for a range of reasons within child detention in the Northern Territory, including to maintain the orderly conduct of the detention centre, the Royal Commission emphasised that the use of restraint for non-emergency reasons was contrary to human rights standards.[775] In this context the Royal Commission recommended that the Northern Territory Government 'prohibit expressly force or restraint being used for the purposes of maintaining the "good order" of a youth detention centre or to "discipline" a detainee'.[776] Further, it recommended the following conditions for the use of force against children in detention:

- use of force be permitted only in circumstances where all other measures have failed
- the use of force be permitted only to protect a detainee, another detainee, or another person from physical injury

- the use of force be applied only by persons trained and holding a current qualification in physical intervention techniques on children and young people
- the use of force be proportionate in the circumstances, and take into account the detainee's background, age, physical and mental circumstances
- mandate that a verbal warning be given before force is used, and the detainee given a reasonable period of time to comply, except in emergency circumstances, and
- the superintendent ensure any detainee injured by use of force is examined by a treating doctor or nurse and clinical notes be recorded.[777]

Throughout the above discussion, a principle underpinning use of violence is that it must be authorised and be subject to review. In this context, it would be unacceptable for unlawful violence to be carried out with impunity by private individuals. In States that lack the capacity to ensure legitimacy and authority in the exercise of violence there is failure of the rule of law.[778]

Accountability and neutrality in use of the State's monopoly over violence is also relevant for considering the function of the rule of law. The discriminatory use of the State's monopoly on violence against particular populations, such as racial minorities, highlights a different way in which 'the rule of law' can fail to be realised. Growing concerns about militarisation of police forces, combined with overt racialised targeting, have led to calls for increased accountability in relation to police use of State violence, and demands to 'defund the police.'[779]

However, the problem of who has a legitimate right to use violence goes beyond regulation of organised private militias, or the accountability of the police, and extends to interpersonal forms of violence. For example, central to feminist discussion of gender-based violence is the historic impunity granted by legal systems for men to carry out domestic and sexual violence, which contributes to the maintenance of patriarchy as a social relation.[780] In this context, continuing violence against women represents a failure of the rule of law.[781]

Restrictive practices against people with disability operate in a way which is at odds with the norms discussed above. If we consider for example the operation of restrictive practices within NDIS services, this operation undermines the State's monopoly on the authorisation of violence and more importantly, challenges the rule of law. First, the authorisation regime for the use of restriction is explicitly partial, since not all restrictive practices are 'authorised'. The legislation allows for authorisation of restrictive practices and utilises behaviour support plans as part of this authorisation regime.[782] However, as indicated in section 5.2.1, unauthorised restrictive practices are *not* expressly prohibited, indeed, a mechanism is provided to report unauthorised restrictive practices, potentially granting these practices legitimacy. This approach effectively provides a weak form of regulation, and potentially enables large scale use of non-authorised restriction – such as the approximately 1 million reported unauthorised incidents of restriction

previously described – and likely large-scale under-reporting. In other words, a significant portion – perhaps most – of the violence directed at people with disability through use of restrictive practices within the context of NDIS services is not explicitly 'authorised' through a process that is accountable to the State. This effectively means that this violence is carried out by organisations operating in a 'private' capacity with loose or non-existent regulatory oversight.

Second, restrictive practices within the context of NDIS services, whether regulated or otherwise, are *not* carried out by personnel who are explicitly acting on behalf of the State in the way that we might associate with the police function. As discussed above, police have a strongly defined role in using force on behalf of the State with legislative and policy oversight and systems of accountability. Police force personnel are required to undergo a rigorous application process with health and fitness assessments, and take part in substantial training, with modules explicitly on the use of force.[783] It was noted above that private security personnel, while not possessing additional rights to use force above that of private citizens, are still subject to regulation in Australian jurisdictions; this extends to training, including in 'techniques using the minimum amount of force necessary to remove the immediate threat while avoiding vital areas of the body and without harming subjects.'[784] With the exception of plain clothed officers, police maintain strict uniform policies and there is typically an offence for individuals who wear police uniforms but are not designated police officers.[785] Unarmed private security guards may not be required to wear uniforms, but can be required to publicly display a licence.[786]

However, in contrast, it is striking that legislative and policy documentation in relation to NDIS restrictive practices provides little guidance on what personnel can carry out these practices. The *National Disability Insurance Scheme* (*Restrictive Practices and Behaviour Support*) *Rules 2018* focus on registered NDIS providers as the entities empowered to carry out restrictive practices, rather than individual staff. This distinction means that organisations, rather than individuals, are framed as carrying out these practices.[787] To an extent this is replicated in State and Territory legislation and policy. For example, the 2019 Victorian Senior Practitioner *Guidelines and Standards for Physical Restraint* are directed at 'disability service providers and registered NDIS providers'.[788] The word 'staff' is mentioned only a handful of times in the document with little prescription on who can carry out these practices.[789] The draft NSW Persons with Disability (Regulation of Restrictive Practices) Bill 2021 refers to NDIS providers, but says very little about staff carrying out restrictive practices. Indeed, in this draft Bill, individual actors arise as a concern in the Bill in Part 7, where people acting under direction from an NDIS provider using an authorised practice are granted immunity 'from any civil or criminal liability.'[790] While the NDIS Quality and Safeguards Commission *Regulated Restrictive Practices Guide* discusses training, it is again striking how little information is provided on the kind of training required to carry out restrictive practices, how intensive it might be, and selection of candidates for this training.[791]

In other words, the NDIS rules and regulations establish a unique 'force' of individuals empowered to use force [or employ violence] against people with disability. The regulations create a cohort of organisations that are authorised to manage use of restrictive practices.

These organisations delegate the capacity to use restrictive practices to individuals associated with the organisation. This delegation occurs in a loose and presumably discretionary fashion, without strong requirements for selection and rigorous training of individuals, and with no requirements for uniforms or similar to mark out individuals who have this capacity to use restrictive practices. These individuals are granted discretionary powers to use violence. Additionally, while the general movement of legislation is towards regulation and authorisation of all restrictive practices within the NDIS, there remains capacity for unauthorised use. As indicated above, perhaps most restrictive practices that occur in the context of NDIS services are unauthorised, and each of these incidents represents a discretionary decision by individual staff to use violence. There is oversight in the regime through the NDIS Quality and Safeguards Commission, however, there remain problems with under reporting, and further, as suggested by the proposed Persons with Disability (Regulation of Restrictive Practices) Bill 2021 (NSW), immunity is effectively granted to staff from civil and criminal liability.

A similar issue exists in the context of use of restrictive practices on people with disability in residential aged care. The *Quality of Care Amendment* (*Restrictive Practices*) *Principles 2022* (Cth) amended the *Quality of Care Principles 2014* (Cth) to temporarily enable specified third parties beyond formally appointed substitute decision-makers – such as a family member or care partner and medical treatment authorities – to consent to restrictive practices in the absence of an individual having capacity to consent and a formally appointed substitute decision-maker (such as a guardian) to provide consent.[792] The effect of this amendment is to broaden the categories of third parties who can consent to use of restrictive practices in residential aged care, both removing the role of judicial and tribunal oversight of the initial appointment of substitute decision-makers in relation to these third parties, and providing immunity to residential aged care providers and specific individuals who use restrictive practices pursuant to the consent of these third parties (where such use would previously have been unlawful).[793] In examining the compatibility of the *Quality of Care Amendment* (*Restrictive Practices*) *Principles 2022* (Cth) with international human rights, the Parliamentary Joint Committee on Human Rights noted a number of human rights issues with the use of restrictive practices in the absence of an individual's consent. It noted the absence in the amending legislation to 'provide for supported, rather than substitute, decision-making' and that 'the consent arrangements in this instrument are highly complex and much depends on aged care providers understanding the complex hierarchy and understanding the interplay between this legislation and relevant state and territory laws'.[794] The Parliamentary Joint Committee on Human Rights also observed that 'specifying persons who may consent for the purposes of granting immunity from all civil and criminal liability to those who rely on that consent, engages and may limit the rights of persons with disabilities to equal recognition before the law, equality and non-discrimination, and access to justice and has implications for the right to an effective remedy.'[795] The Parliamentary Joint Committee on Human Rights recommended that 'further consideration should be given as to whether the consent model to the use of restrictive practices is the best approach to protect the rights of aged care residents', including through 'extensive consultation' and 'a broad ranging inquiry'.[796]

The point of making the above observations about the different regulation that accompanies the use of force within the context of NDIS services is not to argue for the extension of police power to disability services. Nor is the point to argue that care and support staff should be uniformed or be reconstituted as security personnel; nor to argue that exceptional circumstances do not exist where individuals may need to be protected from harm. Rather, the discussion above highlights the stark discrepancies between the way the use of force is regulated outside of disability contexts in comparison with how the use of force is regulated with NDIS services. This discrepancy poses challenges how the rule of law might be understood.

In the context of NDIS services, elements of accountability and transparency are either missing or only appear in a weaker form. As described above, restrictive practices under the NDIS are carried out by personnel who are authorised by organisations with minimal requirements for training. These practices occur in closed environments with low levels of public scrutiny, and minimal use of technologies to monitor use of violence. Finally, as described in Chapter 1, use of restrictive practices is at odds with obligations to prevent torture, cruel and inhuman treatment or punishment and obligations to protect people with disability from violence. In the context of NDIS services, these are carried out by definition on a differential basis, since they are only applied to participants in the NDIS, that is people with disability. As argued in Chapter 1, the differential use of restrictive practices against people with disability is at odds with the non-discrimination obligations of Article 5 of the CRPD. It may further be noted that this discrimination exists as a contradiction within the NDIS, since the legislation underpinning the Scheme has an object which aims 'to give effect to Australia's obligations under the Convention on the Rights of Persons with Disabilities.'[797] As described above, the implicit acceptance of unauthorised restrictive practices essentially removes much of this violence from any realistic oversight.

The above discussion is focused on the context of NDIS service provision; however, similar observations could be made about use of restrictive practices in other contexts, such as in mental health facilities or residential aged care facilities. The problem remains: current policy and legislation enables discretionary use of violence by individuals who are only loosely authorised, trained and monitored, and who are not directly accountable to the State. Importantly, this use of force is frequently – at least in the context of disability services – authorised in an expressly discriminatory way.

As indicated in the introduction to this section of the report, at least in the disability service sector, reduction and elimination of restrictive practices is said to be achieved through investment in at least three core activities: regulation and monitoring; authorisation; and positive behaviour support. In this sub-section of the chapter we considered what it means to take an 'authorisation' approach to restrictive practices, and have outlined several issues with this approach. In the previous sub-section, we considered regulation and monitoring activities, again, outlining several areas of concern. We now turn our attention to the third activity Australia is undertaking for the purposes of reducing and/or eliminating restrictive practices in the disability service sector (and elsewhere): positive behaviour support.

5.3.3 Positive behaviour support and behaviour support plans

As stated above, in this sub-section of the report we consider positive behaviour support and behaviour support plans. Specifically, we attend to the third set of research questions posed by the Disability Royal Commission for this project, being: is positive behaviour support effective in reducing and eliminating the use of restrictive practices? It is more effective in relation to certain types of disabilities, certain restrictive practices, or certain settings?

Positive behaviour support (PBS) has its origins in school context, but has, in recent years, been used in institutional and community-based settings with adults with disability. While there is debate about the best definition of PBS,[798] one of the most frequently cited definitions was developed in 2002 by Carr and colleagues. This definition states that:

> PBS is an applied science that uses educational methods to expand an individual's behavior repertoire and systems change methods to redesign an individual's living environment to first enhance the individual's quality of life and, second, to minimize his or her problem behavior […] The primary goal of PBS it to help an individual change his or her lifestyle in a direction that gives all relevant stakeholders (e.g., teachers, employers, parents, friends, and the target person him – or herself) the opportunity to perceive and to enjoy an improved quality of life. An important but secondary goal of PBS is to render problem behavior irrelevant, inefficient, and ineffective by helping an individual achieve his or her goals in a socially acceptable manner, thus reducing, or eliminating altogether, episodes of problem behavior.[799]

While the above definition of PBS is useful, it is worth noting that the boundaries of what is understood as comprising PBS are potentially broad, and include a range of individual focused strategies. Relevant to this report, is the understanding that PBS in disability settings will typically tie together individual strategies and responses to behaviour, with use of restrictive practices under a set of pre-determined circumstances. This version of PBS might be understood as an individualised support approach that can also function as a means for regulated uses of restrictive practices. In so far as this regulated approach to use of restrictive practices might be useful for reducing and elimination restrictive practices, it has found favour with some advocates and practitioners.

To aid the investigative focus of the Disability Royal Commission, the research team undertook a review of the scholarly national and international literature on PBS as part of the research project. In the sections below we summarise five key themes to emerge from that review in relation to the effectiveness of PBS in a range of settings. Notably, as outlined in the introduction to this chapter, while our review of PBS research considers the use of PBS in a range of settings – specifying those settings as they relate to the research findings – it is not possible from the research literature currently available to generalise if PBS is more or less effective in certain settings. Nor is it possible from current research literature to determine if there is a difference in effect when PBS is used in relation to certain types of disabilities, or used in the context of certain restrictive practices. Further research will be required to address these particular areas of interest for the Disability Royal Commission.

5.3.3.1 An evidence-base with distinct limitations

Our review of national and international literature on PBS suggests that this evidence-base is characterised by two core limitations. First, many studies of the effectiveness of PBS are based on very small sample sizes. For instance, a 2021 pilot study of the acceptability and usefulness of the FAB [Family-directed Approach to Brain Injury] Positive Behaviour Support program included two family members,[800] while a 2015 investigation of the effectiveness of family-centred PBS of young children with disability considered the effects of PBS on three families.[801] There are also several studies of effects of PBS which are based on a single case study design (i.e., they focus on the effect that has occurred in relation to a single person).[802]

Second, much of the PBS evidence-base raises questions about the strength, accuracy and integrity of the findings. For instance, a 2007 systematic review of 65 studies on the effectiveness of behavioural interventions with children and adults deemed to have behaviour 'disorders' after sustaining a Traumatic Brain Injury, found that this body of evidence could not be classified as very strong.[803] A 2012 meta-analysis of 20 studies published over a 16-year period in the context of School-Wide PBS (SWPBS) found a lack of attention to treatment integrity. As the meta-analysis explained: '[w]ithout an accurate measure of integrity, the notion of student non-responsiveness within an RTI [response to intervention] model is effectively invalidated by a lack of understanding whether the treatment has been delivered as intended and at the expected dosage.'[804] Crucially, the authors of this study concluded that 'the need for further study on SWPBS cannot be understated considering its widespread implementation […] If SWPBS implementation precedes this research agenda, it will lack a robust evidence base.'[805]

Similar findings have been made recently. In 2019, a systematic review was conducted into fidelity measurements – that is, the extent to which an intervention is implemented and delivered as indicated in the protocol – in complex interventions for people with intellectual disability and perceived 'behaviours of concern'. Not only did this study find a paucity of randomised controlled trials based on PBS principles, but additionally, that there was 'variable and inconsistent descriptions of how fidelity was measured and reported in the studies'.[806] This means that it is currently unclear if therapists in the studies reviewed were deviating from protocol and compromising delivery.

Finally, in 2020, a meta-analysis of 30 studies of family-centred PBS published between 1997 to 2019 was conducted. This meta-analysis found that less than half of the studies (43.3 per cent) met the WWC (What Works Clearinghouse) design standards – a measure for assessing the quality of research – with:

> (a) insufficient phases necessary to document a functional effect (e.g., multiple baseline design across two family routines); (b) insufficient number of data points in a phase necessary to document either stability or trend (e.g., baseline phase with only 2 data points); and (c) insufficient immediacy of observation sessions just prior to intervention phase in

multiple probe designs, which diminishes documentation of the immediacy of effect from baseline to intervention phases.[807]

Of the 12 studies that did meet WWC design and evidence standards, all met the first criterion – a minimum of five rigorous single case research studies – and the second – at least three different research teams across three different locations – but did not meet the third criterion of needing at least 20 cases. This led the researcher to classify this evidence base as 'emerging' and not established.

5.3.3.2 A focus on staff training as a mechanism for improving the quality of life of people with disability

In addition to the above limitations, the evidence-base for PBS is further characterised by a focus on staff training in PBS, as well as staff beliefs and experiences in using PBS .[808] There is much to be gained from training staff in the context of PBS. It has, for example, been shown that when staff receive training in multi-element behaviour support, there can be significant reductions in the number of staff who believe perceived 'behaviours of concern' arise from efforts by a person with disability to seek attention or gain a positive outcome, and significantly more staff who instead attribute perceived 'behaviours of concern' to being an escape or avoidance response by people with disability, or as something which is done in response to boredom, isolation and a lack of meaningful activity.[809] However, it is worth noting that the current focus on staff training is underpinned by particular assumptions about the connection between staff training and positive outcomes for people with disability, in particular, improved quality of life. It appears to be assumed that: (a) because frontline staff are the primary implementers of PBS, and (b) because properly implemented PBS is said to lead to reduced perceived 'behaviours of concern', which in turn reduces the perceived need for restrictive practices, and this outcome in turn improves the quality of life for people with disability, then (c) staff training to properly implement PBS contributes to the quality of life of people with disability.[810] Connected to this series of assumptions is the commonly held belief within much of the PBS literature that what contributes to the social exclusion of some people with disability, particularly people deemed to have developmental disability, is their perceived 'behaviours of concern'.[811]

Before considering the evidence-base for these assumptions about staff training, perceived 'behaviours of concern', restrictive practices, and the quality of life of people with disability, it is necessary to note two definitional points of tension. First, as outlined in Chapter 3, so-called 'behaviours of concern' are best understood as both 'adaptive behaviours to maladaptive environments',[812] and as communications of distress, resistance and protest in a historical context of vulnerability and dependency where others (i.e., service providers, teachers) have been empowered to interpret the behaviours of people with disability as 'dangerous, frightening, distressing or annoying'.[813] It is unclear the extent to which an assumption that a person's perceived 'behaviours of concern' contributes to their social exclusion recognises these relational, environmental and structural elements. Second, as Hayward and colleagues explain, these assumptions put forth a very narrow understanding of quality of life for a person with disability:

> Reductions in restrictive practices do not necessarily indicate improved quality of life. Positive behaviour support requires that outcomes are measurable and positive […] equating positive behaviour support implementation to reductions in restrictive practices does not equate to desirable outcomes.[814]

Perhaps this is why when we look to the evidence to support these assumptions about the connection between staff training and the improved quality of life of people with disability, we find it lacking. In part this limitation occurs because this connection, while assumed, is infrequently studied. Indeed, a systematic review of the effect of staff training in PBS found that very few studies have considered the connection between PBS training and improvement of support/increased quality of life for people with disability.[815]

However, when the connection between staff training and perceived 'behaviours of concern' or quality of life of the person with disability is studied, the evidence is still lacking. For instance, the aforementioned systematic study of the effect of staff training in PBS noted that the one study that reported directly on quality of life outcomes[816] could not measure or report on these outcomes beyond positive anecdotal evidence of lifestyle changes.[817] Similarly, another systematic review of training methods to increase staff's knowledge and implementation of PBS in residential and day settings for individuals with intellectual and developmental disability only found one study which measured quality of life, and again found no significant change reported.[818] Likewise, a 2019 process evaluation of a randomised controlled trial of PBS-based staff training for perceived 'behaviours of concern' in adults with intellectual disability in the UK found that despite the training being 'well received by most stakeholders',[819] with stakeholders reporting gaining a better understanding of the function of behaviour, the training 'did not reduce challenging behaviours for people with intellectual disability compared to treatment as usual'.[820] Explanations provided for this lack of effect included: aspects of PBS related work being frequently omitted by therapists; therapists finding routine care pressures insurmountable, and thus not carrying out the research task in full; PBS plans lacking detail and not being delivered as initially intended.[821]

Finally, it is worth noting that evidence for improved quality of life for people with disability as a result of PBS is also lacking in studies considering other components of PBS implementation, not just in studies of staff training. For instance, a 2018 randomised controlled trial of setting-wide PBS in supported accommodation settings found that despite the experimental settings in the trial showing a significant improvement in the quality of social care after the trial – for example, by adapting the physical environment to the needs of the person, increasing positive communication and interaction with staff, maintaining and developing new social relationships with friends and family, and scheduling a variety of activities that meet the persons routines and preferences – the quality of life of the people with disability residing in these experimental supported accommodations settings was not significantly improved by the trial.[822]

5.3.3.3 A focus on the quality of plans, which prove to be poor quality

Related to the focus on staff training in the PBS literature is a focus on the quality of behaviour support plans. The literature appears to evince a belief that better staff training and knowledge

of PBS will lead to better behaviour support plans being developed for people with disability. These better plans are then assumed, again, to lead to positive outcomes for people with disability. In the Australian context, there have been several studies into the quality of behaviour support plans, and factors affecting their quality. Much of this research suggests that many behaviour support plans used in relation to people with disability are of poor quality. In 2010, for instance, there was a study of behaviour support plans for people with intellectual disability in Victoria, both pre- and post- the introduction of the *Disability Act 2006* (Vic). This study found that legislative and policy changes, such as the introduction of the *Disability Act 2006* (Vic) – which brought a requirement for behaviour support plans to be developed for individuals subject to restrictive practices – 'do not necessarily lead to practice improvements in the area of behaviour support planning'.[823] Indeed, the behaviour support plans assessed in this 2010 study were found to be 'unlikely to meet the behaviour support needs of the individuals for whom they were written'.[824] It is worth noting, however, that since this article was written, there has been work to establish specific PBS practitioners who work with disability service providers and clients to develop individual BSPs in Victoria. We were unable to find research that evaluated the effectiveness of these developments.

In 2011 a preliminary investigation was undertaken into the utility of the Behavior Support Plan Quality Evaluation Guide II (BSP-QE II) for assessing the quality of behaviour support plans developed by staff supporting adults with intellectual disability in community-based services in Australia. This investigation found that while Australian practitioners consider the BSP-QE II 'relevant and important',[825] when the BSP-QE II was then used to evaluate a sample of 60 behaviour support plans for adults with intellectual disability in community-based residential and day service settings, these plans were found to be 'poor' quality.[826] In contrast, a 2014 evaluation of PBS training provided to six staff in a secure forensic setting in Queensland was conducted finding that plans prepared by trained participants were categorisable as 'good' on the Behavior Support Plan Quality Evaluation Guide II – meaning they are likely to affect change in behaviour. However, the study further concluded that although 'training provided over a number of sessions, incorporating practical support and with a heavy focus on coaching and mentoring delivers useful outcomes for participants', it is unknown if 'high quality plans can be deployed effectively when they are passed from the clinical authors to operational staff for application', with outcomes for people with disability also unknown.[827] Finally, a 2016 Queensland study evaluated the quality of 139 behaviour support plans for technical accuracy and appropriate readability. It found that the mean Behavior Support Plan Quality Evaluation Guide II score was 'remarkably low'.[828] In contradiction to the 2010 Victorian study above, the study found an 'apparent benefit of prescriptive legislative frameworks motivating practice change',[829] with plans scoring highest in domains that are directly related to requirements under the *Disability Services Act 2006* (Qld).

5.3.3.4 Mixed and inconclusive results about the effectiveness of PBS

Perhaps one of the most significant findings to emerge from our review of the PBS literature is that this evidence-base comprises mixed or inconclusive evidence of success. There are, for example, several studies which note positive outcomes. For instance, the first meta-analysis on

school-wide PBS (SWPBS) was published in 2012. This meta-analysis focused on examining effects of SWPBS across different school environments, with twenty studies included in the analysis. The analysis found that: 'SWPBS's effect on problem behaviour was in the low average range, as measured by direct observation',[830] and that 'the effect of SWPBS in the classroom had a significantly lower mean effect size than in unstructured settings' such as the cafeteria, hallways and during recess.[831]

A 2005 study of person-focus training found there was a 77 per cent reduction in frequency of perceived 'behaviours of concern' in people with disability who received residential services. In this context, residential services included large residential settings, community-based hostels, and community-based group homes. Notably, the frequency of perceived 'behaviours of concern' was reduced to an average of 65 per cent for people with disability living in large residential settings. The authors of the study note that such settings had 'relatively poor quality' physical environments, a shortage of options for meaningful activities and day placements, restrictions to community facilities and infrequent contact with family.[832]

Positive outcomes were also found in a randomised, single-blind controlled trial of a specialist behaviour therapy team for perceived 'behaviours of concern' in adults with intellectual disabilities in England. The specialist team provided standard treatment plus applied behavioural analysis to 63 male and female service users with mild to severe intellectual disability. The study found this approach led to a significant reduction in overall scores on measures of perceived 'behaviours of concern'.[833] In this case, the measures of perceived 'behaviours of concern' were categorised in the study as: irritability, lethargy, stereotyped behaviour, hyperactivity, and inappropriate speech.

Notably, several studies with positive outcomes are subject to the limitations previously described. For instance, a 2015 Taiwanese investigation of the effectiveness of family-centred PBS of young children with disability considered the effects of PBS on three families. The study found that in relation to these three families, PBS interventions resulted in: 'improvements in off-task and non-compliant behaviours'; decreased stress for families; and increased acceptance of the PBIS (Positive Behaviour Interventions and Support) approach.[834] At the same time, the study notes that it is unclear if 'families actually ascertained the concepts of PBIS for their children' or if changes in the home environment impacted treatment effectiveness.[835]

Similar mixed results were provided in a 2012 meta-analysis of 83 studies relating to the implementation and effectiveness of FBA-Based Interventions implemented in schools between 2005 and 2008. This meta-analysis found that while there has been an increase in use of individualised PBS in school settings during this time period – with moderate effect sizes for reducing problem behaviour and increasing appropriate skills – there were a number of deficiencies with this body of work. One key deficiency was that only 20 per cent of studies assessed maintenance of the change, with only 4 of the 83 considering this maintenance beyond 2 months – this raises questions about durability.[836] Likewise, a review of 29 studies examined the impact of

school-wide PBS across the United States and Europe. It concluded that school-wide PBS has 'a statistically significant and meaningful effect on behavior, academics, and organizational health'.[837] At the same time, the review further noted that all the results of the studies included would be considered small, and only seven of the 29 studies met WWC standards without reservation, while 12 met WWC with reservations, and 12 did not meet the standards.[838] Finally, a 2021 Systematic review of 29 articles that examined the effectiveness of applied behaviour analysis and PBS in forensic settings found that there was some degree of success, but that the limitations of the evidence-base – poor methodological quality, limited amount of studies available – reduces the capacity of researchers to understand effectiveness in this setting.[839]

Notably, some studies with positive outcomes only produce positive outcomes in relation to some elements, but not others. For example, a 2012 study conducted in Victoria considered whether use of quality behaviour support plans reduced use of restrictive practices. Analysing 198 behaviour support plans submitted to the Victorian Senior Practitioner between 2010 and 2011, the study made several important findings. First, the study found that behaviour support plans which included information about the *function* of behaviour had the strongest effect on reducing restraint and seclusion. Second, that 'individuals with high quality plans showed a decrease in the number of restraint episodes following the authorisation of their plans, whereas, individuals with low quality plans showed no change or an increase'.[840] However, and at the same time, the study further showed that 'those with high quality plans experienced more frequent restrictive interventions prior to and during the BSP [behaviour support plan] period than people with poor quality plans'.[841] The authors posited that this finding could be explained by reference to the following factors: people with disability with higher support needs are more likely to live in institutions and supported accommodation settings; people living in these settings are subject to more oversight; this oversight contributes to both higher quality behaviour support plans being developed, as well as higher uses of restrictive practices.[842] As outlined in Chapter 4, the most use of restrictive practices occurs in these settings.

Finally, some studies draw inconclusive findings, or findings of no effect. A meta-analysis of 26 single-case design studies 'Tier 2' behaviour interventions implemented within educational framework of school-wide PBS, found that the effect sizes reported in these studies were insufficient to establish conclusive findings.[843] Similarly, a 2007 control group study of service user outcomes of staff training in PBS using person-focused training found that while person-focused training led to a reduction in perceived 'behaviours of concern' for the 30 people with disability in the target group, 'it remains unclear what ingredients of these behaviour support plans are most effective'.[844] Finally, a multicentre, cluster randomised controlled trial involving 23 community intellectual disability services in England, was conducted in 2018. The trial sought to determine if staff training in PBS is clinically effective in reducing perceived 'behaviours of concern'. To test this theory, data was collected from 246 adults with intellectual disability over a 12-month period. Staff training in PBS was not found to reduce perceived 'behaviours of concern'.[845]

5.3.3.5 The relationship between the environment and the person

The final key theme to emerge from our review of the PBS was that in studies that provided details about the nature of the 'intervention' that took place to produce a positive outcome, what appears to have changed is the quality of the environment and service being provided to the person with disability. For example, in the randomised, single-blind controlled trial of a specialist behaviour therapy team for perceived 'behaviours of concern' in adults with intellectual disability in England previously described a 'patient perspective' case study was provided. This case study described 'Ms. A', a 25-year-old woman with moderate intellectual disability and limited verbal communication. The case study indicated that Ms. A's reported behaviour included 'ignoring most requests made to her, sitting down on the floor or pavement and refusing to get up, kicking out at caregivers, hitting her head, and pulling her hair out'.[846] The specialist behaviour therapy team observed that Ms. A 'had more frequent contact with staff than she wished for; she appeared disengaged for 70% of the observed time; and she had very little participation in household tasks'.[847] It was also observed that Ms. A was more likely to hit out at caregivers or to hurt herself if others use confrontational approaches towards her or if she was bored. It was therefore proposed that staff use nonconfrontational and non-aversive techniques, as well as improve the social and emotional aspects of her living environment. These actions – which in any other context would be considered a standard of good service delivery and basic respect – led to a decrease in her 'behaviour'.

A similar case example of changes to the environment leading to positive outcomes was provided in a 2017 single case study of a person with Huntington's disease with high levels of aggression, who received a behaviour support intervention and sensory modulation (i.e., weighted blanket, click-clack ball and vibrating massager).[848] This study found that 'the combined therapy approaches worked well in tandem, with sensory modulation techniques deescalating early agitation, and behaviour modification reducing the frequency of identified environmental and behavioural triggers'.[849] Importantly, the study found that the behaviour support plan was 'most helpful at eliminating several common triggers for aggression including eating meals in the noisy common areas, being physically assisted with his meals, being directly questioned and being concerned that he was being closely observed/monitored.'[850] Again, attention to the particular needs and preferences of an individual – a feature of good service delivery – would presumably have prevented such issues from arising in the first place.

Finally, a 2020 single case study of an 18-year-old man with autism reduced 'self-injurious behaviour' from 20-25 times a day to 1-2 times a week. Notably the factors identified as contributing to this reduction included when: staff were consistent in their approach and tone and volume of voice; the man was enabled to access activities, encouraged to reintegrate activities he previously enjoyed and was allowed to 'venture outside at his own pace'; excessive stimulation was reduced from the built environment; a 'communication passport' was developed to communicate wishes and demands; and the man was taken off medication that was 'inappropriate to his needs'.[851]

While we acknowledge that the evidence provided above suffers from one of the same limitations previously identified with the positive behaviour support literature in general – i.e., studies of small sample size – we find these case study accounts important because of what they appear to suggest about the effectiveness of positive behaviour support. Specifically, these case studies appear to suggest that positive outcomes occur for people with disability when: (a) staff are nonconfrontational and consistent in their communication with the person with disability; (b) staff do not impinge on the autonomy of the person with disability; (c) people with disability are enabled to participate in meaningful activities of their choosing; and (d) the wishes of the person with disability are listened to and acted upon. Such findings are consistent with our understanding (explained in Chapter 3), that perceived 'behaviours of concern' are distress, protest and resistance made in a context of maladaptive environments of concern. The findings are also consistent with the research evidence (mainly relating to people with psychosocial disability) about reduction and elimination of restrictive practices discussed earlier in this chapter. These findings also raise important questions about the standards and quality of contemporary disability services and supports, and whether what is required is greater accountability of services rather than behavioural interventions in individuals receiving those services.

5.4 Summary and concluding thoughts

This chapter addressed the second, third and fourth sets of questions outlined by the Disability Royal Commission for this project.

The first section of the chapter focused on RQ2: What measures and strategies are most effective in addressing these drivers and reducing or eliminating the use of restrictive practices against people with disability? Does this differ by setting, or by the type of restrictive practice? What measures have been proven ineffective in addressing restrictive practices?

In that section we focused on the 'high-level' frameworks and principles used to guide current national approaches to reducing and/or eliminating restrictive practices in different systems and service settings. As explained, there are several gaps in both data collection and research literature which make it difficult, if not impossible, to speak with any certainty about the effectiveness of current national approaches. Likewise, it is not possible from the limited material currently available to identify if there are differences in effectiveness between settings, or by the type of restrictive practice. Further research will be required to address these particular areas of interest for the Disability Royal Commission.

What we were able to provide instead were three observations of common features among the 'high-level' frameworks and principles used to guide current national approaches to reducing and/or eliminating restrictive practices in different systems and service settings. First, we observed a lack of set targets and indicators of progress for most 'high-level' frameworks and principles in Australia. Arguably this lack of targets and indicators contributes to the lack of information currently available about the effectiveness of different measures and strategies both in general, in different settings, and in relation to different types of restrictive practices.

Second, we observed an emphasis on positive behaviour support approaches in disability service and educational settings. Third, we observed an emphasis on workforce development, training and education. As explained, in section 1, while we are unable to speak to the direct effect of this emphasis on outcomes in Australia, the broader research literature indicates that some training can lead to counterintuitive results, including an increased use of restrictive practices by staff.

In the second section of this chapter, we attended to RQ4: Are there local and international models of policies and practices that have resulted in effective reduction in the use of restrictive practices? Here we provided an overview of a selection of 'high-level' frameworks, principles and approaches used to guide international approaches to reducing and/or eliminating restrictive practices. We also provided detailed case studies of three key international approaches to reducing restrictive practices that have had some success in reducing restrictive practices.

Importantly, as explained, all three examples we considered were developed in the context of mental health settings. As addressed in that section, while there have been attempts to implement these approaches in other settings, including disability services settings and educational settings, their effectiveness in these other settings has not been fully evaluated. Furthermore, as demonstrated in that section of the chapter, while some of these international approaches have been adopted in Australian mental health settings, their effectiveness in the Australian context is either untested at this time (as was the case with the Six Core Strategies) or has led to mixed results (as was the case with the Safewards Model).

In outlining these case studies, we identified two common features among these successful approaches. First, we observed an emphasis on ensuring strong leadership towards organisational change. Second, we observed an emphasis on organisations taking actions to foster better relationship dynamics in service settings between staff and people with disability.

In the third section of the chapter, we considered the third set of research questions (RQ3) provided by the Disability Royal Commission: Is positive behaviour support effective in reducing and eliminating the use of restrictive practices? Is it more effective in relation to certain types of disabilities, certain restrictive practices, or certain settings?

To help situate the context within which positive behaviour support has emerged in Australian practice, the third section of the chapter examined how Australian governments have begun to operationalise the principles and frameworks for reduction and elimination of restrictive practices. Here we drew attention to three core activities associated with this operationalisation.

First, we considered the establishment of a regulation and monitoring regime for restrictive practices. We drew attention to the 7,862 people with disability who were subjected to a total of 1,032,064 unauthorised uses of restrictive practices in the one-year period of 1 July 2020 to 30 June 2021. We further noted that the primary way that the NDIS Quality and Safeguards Commission intends to reduce these unauthorised uses of restrictive practices

moving forward is by transforming them into authorised uses of restrictive practices, primarily, through the completion of a behaviour support plan. In the second sub-section we considered this 'authorisation regime' in detail. We clarified how this regime allows for discretionary use of violence, often in a highly discriminatory way, by individuals who are only loosely authorised, trained and monitored, and who are not directly accountable to the State. In the final sub-section, we then considered one of the key features of the authorisation process: behaviour support plans made in a context of positive behaviour support. Here we provided a detailed review of the scholarly national and international literature on positive behaviour support. Notably, while that review considered use of positive behaviour support in a range of settings, including schools and adult disability service settings, it is not possible from the research literature currently available to generalise if positive behaviour support is more or less effective in certain settings. Nor is it possible from current research to determine if positive behaviour support is more or less effective when used in relation to certain types of disabilities, or used in the context of certain restrictive practices. Further research will be required to address these particular areas of interest for the Disability Royal Commission.

What we were able to observe from our review of the scholarly national and international literature on positive behaviour support is that the evidence-base for positive behaviour support is characterised by distinct limitations, and often provides mixed or inconclusive results. In practice this means that while there are several studies which find positive outcomes from implementing positive behaviour support approaches, some of these studies have design limitations which mean it is unclear to what extent the positive outcome observed came from the positive behaviour support approach implemented. One consistent, unambiguous finding to emerge from the research is that most studies into behaviour support plans find these plans to be of poor or low quality.

In summarising these various key and common features of Australian and international 'high level' frameworks and principles for reducing and/or eliminating restrictive practices, as well as the 'ground level' approaches adopted in Australia, we might add two final observations here. The research questions set by the Disability Royal Commission seek to determine if there are approaches to addressing the drivers of restrictive practices that are effective in reducing or eliminating use of restrictive practices. Figure 8 below illustrates the ecological system of restrictive practices, including the key drivers and enabler we identified in research literature across Chapters 3 and 4. If we look across the common features of Australian and international approaches to reducing and/or eliminating restrictive practices, we might observe that there has been an emphasis on actions and interventions that have potential to address some, though not all, of the dynamics identified within the 'Relationships' and 'Institutions' circles of the ecological system of restrictive practices. There is, arguably, even potential for some of these actions to hold flow-on effects for the 'Individual' circle.

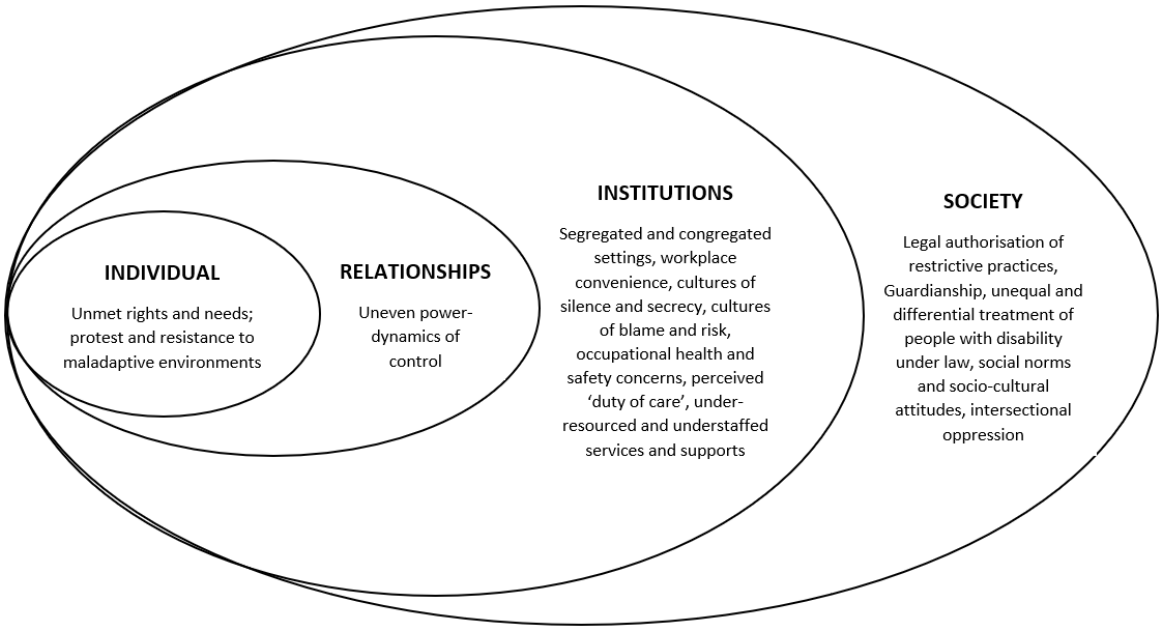


Figure 9: The ecological system of restrictive practices, including key drivers a nd enabler identified in research literature

However, taking an ecological approach to violence prevention involves tracing and exploring the concentric circles of relationships, institutions and social structures that envelop and extend out from that individual, *as well as* an understanding that each concentric circle works in connection with the others. Thus, in taking an ecological approach to violence prevention we must remain attentive to the ways that the 'Individual' dynamics driving restrictive practices are shaped and influenced by the 'Relationship' dynamics. Likewise, we must consider how the 'Relationships' dynamics driving restrictive practices are shaped and influenced by the dynamics of 'Institutions', and how these institutional dynamics are in turn shaped and influenced by those that operate in 'Society'. To this end we might observe that the authorisation and regulation of restrictive practices outlined in detail in this Chapter has previously been identified as a key part of the ecological system of restrictive practices (see Chapter 3), and as playing a crucial enabling role in ongoing use of restrictive practices against people with disability (see Chapter 4). This observation raises a critical question about the potential influence this unchanged 'Society' driver of legal authorisation and regulation of restrictive practices may hold for attempts to address the 'Institutional', 'Relationship' and 'Individual' drivers through the approaches identified in this chapter. Similarly, failing to address segregated and congregated settings – either on the structural level of deinstitutionalisation and desegregation, or on the individual level of giving people meaningful choice and options as to where they live, work, study and receive mental health treatment – might then continue to impact the 'Relationship' and 'Individual' drivers, even if work is done in some of these approaches to address some of the dynamics of service provision within existing settings. While we cannot from the current state of research literature available determine the influence of this unchanged 'Society' driver on the ecological system of restrictive practices, it is possible to consider what other approaches may lead to the elimination of restrictive practices if this fundamental enabler for restrictive practices was addressed. We do this in the next chapter.

Chapter 6: Elimination of restrictive practices

The past four chapters of this report have advanced evidence-based understandings of restrictive practices in two core ways. First, Chapter 2 identified restrictive practices as those which strip people with disability of dignity. Drawing on first-person accounts of people with disability, that chapter spoke to the ways that people with disability experience restrictive practices as violent, traumatic, disempowering, humiliating and dehumanising. The chapter further showed how some people with disability feel abandoned, scared, 'caged' and punished when subject to these practices. Chapter 2 demonstrated how such violence, torture and ill-treatment – whether it occurs as a single event or repeated over time – can fundamentally change both the life of a person with disability, and how that person understands themselves and their future.

The second key advancement of evidence-based understandings of restrictive practices in this report came in Chapters 3 and 4. These chapters traced the ecological system within which restrictive practices take shape and are perpetrated against people with disability. Drawing on first-person accounts of people with disability, as well as empirical research, Chapters 3 and 4 paid attention to the relationships, institutions and social structures that envelop and extend out from the people with disability who are subject to restrictive practices. In so doing, these chapters identified the systematic drivers and core enabler for restrictive practices. These drivers and enablers, as well as their ecological relationship to one another is represented in Figure 10 below.

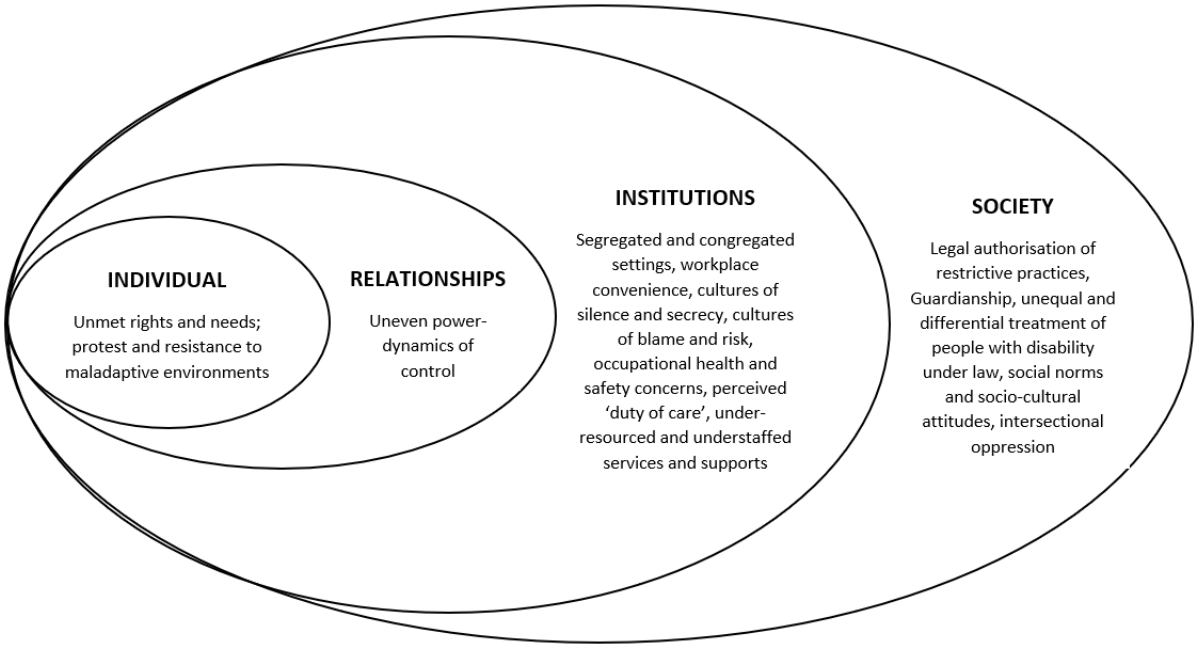


Figure 10: The ecological system of restrictive practices, including key drivers and enabler identified in research literature

In light of the findings of Chapters 2, 3 and 4 we turned in the previous chapter, Chapter 5, to consider some of the core national and international approaches that have been taken over the past decade to reduce and/or eliminate restrictive practices. Given the seriousness of the violation of rights experienced by people with disability with respect to use of restrictive practices, we would expect to see a strong evidence-base informing use of strategies aimed at elimination. However, as outlined in the conclusion to that chapter, there is currently no definitive evidence on what works in terms of eliminating restrictive practices. There is both a lack of formal academic research evaluation of national and international approaches, and evaluations that do exist are either inconclusive, evaluate by reference to the experiences of staff and/or family (rather than people with disability), are typically conducted without reference to human rights, and/or are based on small sample sizes.

Chapter 5 also illuminated a core issue for consideration: it is unclear if and how the current approaches to eliminating restrictive practices address the ecological system within which our evidence-base analysis has demonstrated restrictive practices are driven and enabled, and the broader human rights of people with disability. Accordingly, in this sixth chapter of the report, we offer a third and final advancement in understandings of restrictive practices. We offer a pathway for eliminating restrictive practices that is responsive to the drivers and enabler identified by this report, and which works to realise human rights of people with disability and redress and repair the harm to people with disability through restrictive practices, including restoring the dignity that has been stripped from people with disability.

Before outlining this pathway for elimination, it is important to clarify that the pathway proposed here has not been tested for effect. This point of tension speaks to the fact that the Disability Royal Commission is a world-first opportunity for human rights-led prevention and response to violence against people with disability. Thus, what we propose are steps that are directly responsive to the drivers and enabler identified by this report. These steps are consistent with human rights obligations to people with disability, and they are also consistent with contemporary approaches towards violence prevention more broadly. While these steps have not been tested for the effectiveness in relation to eliminating restrictive practices in relation to people with disability, we provide evidence of where comparable steps have been taken in relation to other populations experiencing violence, abuse, neglect and exploitation. In light of the importance of the right to non-discrimination and equality for people with disability, we should not set a lower standard of what is possible in relation to preventing and responding to violence against people with disability. We should expect that what we can deliver for other marginalised populations we can also deliver for people with disability.

The chapter comprises four main parts, each part attends to one of the concentric circles in the ecological system of restrictive practices explored in Chapters 3 and 4. Notably, in this chapter we move through this ecological system in reverse order. We begin with the concentric circle of social structures, and then move on to consider institutions, relationships, and finally, the individual. We take this approach because we recognise that in the ecological system of restrictive practices, each concentric circle envelops, informs and sustains the one before.

Accordingly, and as will be demonstrated below, when one moves through this ecological system in reverse order, and begins by addressing some of the elements present in the outer circles, some of the elements identified in the inner circles become easier to address, or are no longer apparent.

This method of systematically targeting the drivers of the ecological system of restrictive practices produces an agenda for action – a set of recommendations for the Disability Royal Commission – which might be understood as an 'Eight Point Action Plan to Eliminate Restrictive Practices.' This plan is summarised below at Figure 11.

SOCIETY

1. **Prohibit Restrictive Practices**

End legal authorisation for use of restrictive practices

2. **Change Attitudes and Norms**

Support awareness raising to address discriminatory attitudes and norms

3. **Acknowledge and Address Historical Injustice**

Publicly acknowledge past wrongs, support truth telling

INSTITUTIONS

4. **Deinstitutionalise and Desegregate**

Deinstitutionalise and desegregate environments

RELATIONSHIPS

5. **Recognise the Autonomy and Leadership of People with Disability**

Support exercise of legal capacity

6. **Utilise Trauma Informed Support Approaches**

Reform service systems to recognise and respond to people with disability using trauma informed approaches

INDIVIDUAL

7. **Adequately Resource Independent Living and Inclusion**

Fully resource and realise Article 19 CRPD rights to independent living and inclusion

8. **Provide Redress for Victim-Survivors**

Seek to rectify injustice through law reform and a national redress scheme

Figure 11: Eight-point action plan to eliminate restrictive practices

Finally, before we move through the circles of the ecological system of restrictive practices, it is necessary to state that this ecological system that drives and enables restrictive practices cannot be resolved through piecemeal reforms to existing practices. Restrictive practices are interconnected with society-wide oppression, discrimination and stigma experienced by people with disability. Thus, the ecological system of restrictive practices cannot be effectively addressed through small scale and selective interventions. Rather, there is a need for large-scale institutional change and societal transformation. In this context, there is also a need to take responsibility for the historical injustices perpetrated against people with disability. On this point, the Disability Royal Commission may take guidance from transitional justice approaches.

Transitional justice has been defined by the then United Nations Secretary General Kofi Annan as 'the full range of processes and mechanisms associated with a society's attempt to come to terms with a legacy of large-scale past abuses, in order to ensure accountability, serve justice and achieve reconciliation'.[852] Transitional justice encompasses a range of elements including truth-telling, reparations, and institutional reform. Transitional justice is premised on the necessity of society-wide rupture and widescale change to political and justice systems, culture, and social relations, on the basis that merely tinkering with law and practice allows structural conditions to continue to inform the operation of future systems. Transitional justice enables nations and communities to face their pasts to build a different future. Victim-survivors have a central role in transitional justice initiatives and should be included in design and implementation of transitional justice processes.

A transitional justice approach has been utilised in other liberal democratic nations in relation to systemic violence and human rights violations against other marginalised populations, such as the Truth and Reconciliation of Canada in relation to First Nations peoples,[853] and on police torture of racialised people in Chicago, the Chicago Torture Justice Center, United States of America.[854] Utilising a transitional justice approach in the context of restrictive practices would build on the design and lived experiences of such initiatives, and involve a range of elements including truth-telling about people's experiences of restrictive practices; a redress scheme for people who have experienced restrictive practices; wholescale legal reform to prohibit use of restrictive practices; and reform of the funding and delivery of services and support to people with disability. We elaborate on some of these elements further below.

6.1 Society: Addressing socio-cultural and legal structures that sustain restrictive practices

As Figure 9 indicates, at the broadest level restrictive practices are driven and enabled by socio-cultural and legal structures, including legal authorisation, and social norms and attitudes. To address these structures, we recommend three core actions be undertaken, namely: prohibit restrictive practices; change social attitudes and norms related to people with disability; and acknowledge and address historical injustice associated with use of restrictive practices.

6.1.1 Prohibit restrictive practices

A finding of this report is that in order to eliminate restrictive practices, governments in Australia will need to impose an immediate legal prohibition of use of restrictive practices on a discriminatory basis against people with disability. To be effective, this legal prohibition must respond to the current legality of restrictive practices across a variety of jurisdictions, including guardianship, disability, family welfare, and *parens patriae*, among others. Such a comprehensive approach is necessary irrespective of the scope of the current use of each law. Otherwise, it is possible that laws that are currently rarely used for restrictive practices could provide a residual legality.

This recommendation, no doubt, has far reaching consequences. However, this recommendation is absolutely consistent with obligations under international law, the rights and dignity of people with disability, and established violence prevention principles that have been operationalised in relation to other marginalised populations.

As discussed in Chapter 1, restrictive practices are at odds with international human rights norms. Under international human rights law, torture and ill-treatment are subject to an 'absolute' non-derogable prohibition. This means that under no circumstances can these practices be carried out. Where restrictive practices constitute acts of torture, as defined by Article 1 of CAT, then these acts must be forbidden by law. Further, as discussed in Chapter 1, forms of ill-treatment – that is, cruel, inhuman and degrading treatment or punishment – while not explicitly defined by CAT, are nevertheless understood as subject to the same absolute prohibition.

There is likely to be disagreement on what forms of restrictive practices constitute torture and ill-treatment. However, how torture and ill-treatment are defined is contextual in nature. As discussed in Chapter 1, the discriminatory application of restrictive practices as a response to people with disability, often in health and disability care settings, is almost certainly in violation of obligations to prevent torture and ill-treatment. It is for this reason that in 2013 the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment called for 'an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities […] in all places of deprivation of liberty, including in psychiatric and social care institutions.'[855]

Beyond obligations to prevent torture and ill-treatment, CRPD also stipulates strong immediately realisable obligations to protect people with disability from violence, abuse and exploitation. As discussed in Chapter 1, the right to protection from violence is interconnected with fundamental civil and political rights, including legal personhood, access to justice, rights to bodily integrity, freedom of movement, freedom from arbitrary detention and the right to live independently in the community. This means that even where forms of restrictive practices do not rise to the threshold of torture and ill-treatment, there remain strong obligations under Article 16 of CRPD 'to take all appropriate legislative, administrative, social, educational and other

measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.' Certainly, as indicated in Chapter 1, this view is reinforced by the UN CRPD Committee's guidelines on Article 14 CRPD, which argue that restrictive practices are 'not consistent with the prohibition of torture and other cruel, inhuman or degrading treatment or punishment of persons with disabilities.'[856]

In Chapter 1, this report discussed the important role within human rights law of conceptions of human dignity in informing rights to freedom from torture, ill-treatment and violence. As discussed, use of restrictive practices against people with disability is at odds with obligations to uphold dignity for two reasons. First, these practices themselves fail to recognise the inherent dignity of people with disability. Second, in so far as these practices are used on a discriminatory basis against people with disability, they act as a 'civic marker' which undermines the social standing of people with disability in our society. These observations are reinforced by the testimony of people with disability themselves about their own experiences of restrictive practices. As discussed in Chapter 2, people with disability who experience restrictive practices associate these practices with loss of dignity. Thus people with disability who experience restrictive practices describe the use of these practices as a failure to recognise their inherent dignity: 'It was harmful to my whole being, an assault on my dignity and attack on my soul.'[857] Simultaneously, restrictive practices are understood by some people with disability as one of the many forms of violence and exclusion they experience that dehumanises and devalues their status in society: 'Angry and animalistic … caged, cold … felt treated like an animal.'[858]

We live in societies which are shaped by widespread discrimination and stigma against people with disability. The discriminatory use of restrictive practices against people with disability is one acute example of how an ableist society systematically devalues people with disability. Article 5 of CRPD provides the strong obligation that States must 'prohibit all discrimination on the basis of disability.' The reason this discrimination is forbidden is that all forms of legally and socially sanctioned discrimination on the basis of disability contribute to society wide dehumanisation and devaluing of people with disability; they themselves contribute to the unequal status of people with disability and are not merely a product or reflection of this. From this standpoint, discriminatory use of restrictive practices against people with disability must be prohibited.

In addition to the above rationales for imposing an immediate legal prohibition of use of restrictive practices on a discriminatory basis against people with disability, the finding to prohibit restrictive practices is in conformity with established violence prevention principles which understand legal prohibition as an important steppingstone towards eliminating violence. As discussed in Chapter 4, an enabler of continued use of restrictive practices is legal authorisation of these practices, which facilitates restrictive practices to be used on a discriminatory basis against people with disability, in regulated on unregulated forms. The law certainly permits and regulates certain forms of violence which can potentially be used on a non-discriminatory basis to respond to situations where self-harm or harm to other individuals is conceivable. For example, the 'reasonable force' powers which are provided to police and members of the community, which might extend to the use of restraint and containment.[859]

Further, there is capacity for individuals to respond in emergency situations through Good Samaritan laws, which provide civil immunity for actions 'in an emergency when assisting a person who is apparently injured or at risk of being injured.'[860] Such provisions potentially provide mechanisms by which police and members of the community can respond where there is a serious risk of harm to an individual or to others, and create the capacity for the use of force to be subject to a framework of legal accountability which includes the opportunity for people to be able to seek remedies where force is used illegally. However, these powers do not clearly apply to the discriminatory application of restrictive practices against people with disability in most cases. Moreover, as discussed above, in so far as these practices are forms of torture and ill-treatment, they are at odds with obligations under international law, even if they have authorisation under prevailing domestic laws.

Importantly, it is the continued legal authorisation of restrictive practices which is an enabler for their endurance despite any changes in service practice or shifts in attitudes towards disability. International research supports the view that torture and ill-treatment generally require three enablers: first that torture and ill-treatment require the social and legal sanction to establish a sense that these practices are authorised; second, the practices need to be routinised within the context of the institutions in which they occur so that they appear as 'business as usual' and part of regular work routines; finally, that the subjects of violence must be systematically dehumanised, to prevent individual and institutional moral uncertainty about the continuation of these practices.[861] Legal authorisation of restrictive practices provides one of the central pillars which enables those who carry out these practices – governments, organisations, institutions, staff members – to do so with apparent impunity. Further, as discussed in Chapter 5, authorisation of the discretionary use of these practices against people with disability is one source for the systematic dehumanisation of people with disability in our society. In other words, legal authorisation of restrictive practices violates the inherent dignity of people with disability and is complicit in undermining the status of people with disability in our society. For these reasons, legal prohibition of restrictive practices is a powerful steppingstone towards elimination.

An argument might be made that it would be more effective to *regulate* restrictive practices rather than prohibit them. This argument might be made on the basis that continued legal authorisation of restrictive practices with a tight monitoring and regulation regime might be successful in progressively eliminating these practices over time. It might also be argued that pursuing legal prohibition alone will only lead to the continued illegal use of these practices, combined with a loss of capacity for Governments to monitor and regulate their use (i.e., pushing the practices 'underground'). However, these arguments in favour of regulation are problematic for three reasons.

First, as discussed above, all forms of torture and ill-treatment are forbidden under international law, and there is now an emerging global consensus that discriminatory use of restrictive practices against people with disability constitutes torture and ill-treatment. There is an absolute non-derogable prohibition of torture and ill-treatment. It is impossible to monitor and regulate acts which are legally forbidden, since legal prohibition applies an absolute ban on a specified act (or specified acts) occurring at all times.[862]

Attempts to regulate torture and ill-treatment do not positively reflect the intention behind obligations to prevent torture and ill-treatment. It is for this reason that legal prohibition, followed by systematic attempts to eliminate, has been the approach of international human rights actors in relation to torture and ill-treatment. This approach is reflected in the structure of the international anti-torture framework, which centres a strong absolute prohibition of torture and ill-treatment in CAT and other instruments, and then monitors and seeks to prevent using instruments such as the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

Second, leaving aside the compelling obligation under international law to prohibit restrictive practices, there is also the reality of limited evidence to suggest regulation and monitoring of restrictive practices is likely to achieve elimination. Australia currently maintains monitoring and regulation regimes in relation to restrictive practices; this is certainly the current strategy informing the use of restrictive practices within the context of NDIS services. As discussed in Chapter 5, there is no evidence that monitoring and regulation of the use of restrictive practices has led to a decline in utilisation. Indeed, within the context of NDIS services, *at best* the substantial growth in the recorded use of restrictive practices since the establishment of the new regulation regime simply indicates that we are only now gaining a more accurate picture of just how widespread use of these practices are in the community. However, *at worst*, the data may indicate that regulation of practices – which also have legal and social authorisation – has led to the expansion in use of these practices.

It might be argued that advocates for prohibition should 'wait and see' if monitoring and regulation will achieve change over time, or alternatively argue that there is scope and need for tougher regulation to achieve change. However, several elimination frameworks have already been in place in Australia for close to a decade, and thus there has been opportunity already to witness their ineffectiveness. Moreover, these arguments to 'wait and see' create the non-justifiable circumstance where people with disability are asked to continue to endure practices which are at odds with international law while governments experiment with the right policy settings which it is speculated might – without evidence – lead to change over time. Pursuing our proposed approach would bring violence prevention strategies for people with disability into line with other groups, such as women.

Finally, legal prohibition of the discriminatory use of restrictive practices against people with disability is in keeping with contemporary approaches to violence prevention. Violence prevention approaches combine strong legal prohibition with elimination strategies which aim over time to achieve the social and cultural change required to end prohibited violence. Prohibition is central, for example, to global and national efforts to eliminate violence against women, which requires both a legal commitment to outlaw sexual and domestic violence, and simultaneously, long term efforts to alter cultural patterns and social beliefs that contribute to continued high rates of violence.[863] As outlined in Case Example 2 below, this also reflects the progress that has been made globally in relation to eliminating corporal punishment of children, which relies on both convincing States to legally prohibit these practices, and simultaneously working to achieve social and cultural change to eliminate use of violent discipline methods

against children.[864] Legal prohibition of forms of violence and discrimination which previously had widespread legal and social endorsement – whether we are considering the death penalty, racial segregation of schools, domestic violence against women or corporal punishment of children – is by definition jarring for institutions, professions and individuals, as daily social practices must change, accepted professional practice and disciplinary knowledge must be reassessed, and institutional rules must be reformed. However, as has been shown in different contexts, such as the prohibition of corporal punishment in Australian schools, the radical disruption to social order that is imagined by opponents of change does not need to eventuate. Instead, prohibition of legally sanctioned violence and discrimination is almost always considered in retrospect as an important steppingstone towards elimination of violence and establishment of cultures that fundamentally realise equality and rights.

A final note on the strategies that can be pursued for the elimination of violence which follows legal prohibition. Australia's existing human rights monitoring frameworks provide one avenue to pursue elimination through monitoring of a range of institutional settings, including care and support settings. As mentioned above, an important feature in the international torture and ill-treatment landscape is the OPCAT. This treaty is intended to proactively eliminate torture and ill-treatment by focusing on sites of detention and works in a complementary way to CAT. Article 2 of OPCAT creates a Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment of the Committee against Torture (SPT) which is granted rights to 'unrestricted access to all places of detention, their installations and facilities and to all relevant information relating to the treatment of persons and to conditions of detention.'[865] Additionally, States are required to establish their own domestic National Preventative Mechanism (NPM) with oversight responsibilities for implementing OPCAT. The Australian Government ratified OPCAT in December 2017, and opted to postpone its obligation to establish an NPM for three years.[866] Australian ratification of OPCAT and the development of an NPM is an opportunity to protect people with disability with disability from torture and ill-treatment.[867] This is because, OPCAT applies to wherever 'people are deprived of their liberty,' defined in Article 4 as 'any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority.' Other jurisdictions, such as the United Kingdom and New Zealand, have provided a definition of places of detention that encompasses these settings.[868] The Commonwealth Ombudsman has recently flagged the possibility that Australia's NPMs 'will expand the places they monitor into those areas where people are, effectively, detained, but which go beyond the traditional detention context'.[869] Extension of NPM monitoring to disability and health contexts where people would be a positive addition to elimination and prevention strategies in systematically addressing the ecological drivers of restrictive practices.

Case Example 2: Prohibiting and Eliminating Corporal Punishment against Children

Globally, corporal punishment of adults has been outlawed in most jurisdictions and is regarded by the international human rights community as a form of torture and ill-treatment.[870] However corporal punishment of children, whether in formal institutional settings, or in private and familial settings, is still widespread globally and frequently has explicit legal authorisation. Over recent decades, there has been a growing movement to eliminate corporal punishment of children.[871] To date, 63 countries have legislated for an absolute prohibition of the use of corporal punishment in all settings.[872] Australia has only made partial progress towards prohibition and elimination of corporal punishment against children.

Prohibition and elimination of corporal punishment has largely been achieved in school settings. By the late 1980s and early 1990s, corporal punishment in schools was by and large prohibited in most States and territories, with notable delays to implementation for independent schools in Western Australia, South Australia and Queensland.[873] Examples of legislation to prohibit corporal punishment provide strong and certain language that there is an absolute ban in these settings. For example, Section 35 2(A) of the NSW Education Act 1990 states 'guidelines and codes must not permit corporal punishment of students attending government schools'; while the NSW Government Education Standards Authority stipulates that 'a registered non-government school will have in place and implement policies related to the discipline of students that … either expressly prohibit corporal punishment or clearly and exhaustively list the school's discipline methods so as to plainly exclude corporal punishment'.

The move towards an absolute prohibition of corporal punishment in school settings in Australia has not been without opposition. While a number of community groups, including teachers unions, led the campaign for reform, some independent schools were in opposition to reforms because of perceived concerns relating to student discipline.[874] Even today, there remain members of the community who advocate the return of corporal punishment in schools, arguing that it was 'very effective.'[875] This tension matches negative reactions of some teachers and community members globally when corporal punishment is removed as a legally sanctioned form of discipline.[876] However, the experience of prohibiting corporal punishment in schools in Australia and other jurisdictions demonstrates that a significant step to removing violence that is routinely practiced within institutional settings is possible. It also demonstrates that reform creates opportunities for societies to explore other strategies of education and discipline.[877]

However, the Australian experience also highlights the dangers of *partial* approaches to prohibiting and eliminating forms of violence that are at odds with international human rights norms. A significant concern with the Australian approach to eliminating corporal punishment is that no jurisdictions have moved to prohibit use of corporal punishment

in family settings. Law in some jurisdictions, such as Section 61AA of the NSW Crimes Act 1900, establish a defence of 'lawful correction,' thus providing an exemption from assault laws for the use of corporal punishment against children, and simultaneously regulating the conduct of this violence. As Laetitia-Ann Greeff notes, this has produced the perplexing situation in NSW that: 'under current laws, corporal punishment is lawful in every NSW home. Ironically, corporal punishment is prohibited in NSW in residential and foster care, childcare and family daycare, as well as in public and independent schools, and corporal punishment is not permitted as a disciplinary measure in penal institutions.'[878] In effect, the law in NSW and in other Australian jurisdictions enable parents to exercise the discretionary use of legal force against minors.[879] As Greeff observes, this has significant implications which are 'contrary to the rule of law' and produce perverse messaging about what 'the law says to the child and the value of their human rights when faced with physical violence.'[880]

The progress made internationally in eliminating corporal punishment against children highlights the potential of law and its capacity to prohibit particular actions as a tool in violence prevention. It is clear that prohibition of corporal punishment, rather than attempts to 'regulate' its practice, are most effective in sending a strong message that corporal punishment is against community norms.[881] The NSW example of an attempt to regulate parents and their use of 'reasonable force' against children highlights the problems with utilising regulation rather than prohibition approaches.[882] As stated by the ACT Human Rights Commission, 'a clear prohibition of violence against children makes it more difficult for parents to justify serious physical violence as discipline, and reduces the risk of discipline escalating into unintended levels of physical abuse.'[883]

However, legal prohibition of corporal punishment is itself not enough to eliminate use of corporal punishment. Certainly, as has occurred in some jurisdictions, unless law reform is accompanied by appropriate measures to work towards elimination, then these practices will not end.[884] In its 2006 General Comment on corporal punishment, the UN Committee on the Rights of the Child made clear that in its view that '[g]iven the widespread traditional acceptance of corporal punishment, prohibition on its own will not achieve the necessary change in attitudes and practice. Comprehensive awareness-raising of children's right to protection and of the laws that reflect this right is required.'[885] As Greeff highlights, prohibition of corporal punishment is the first step towards progressive elimination, and part of a broader and ongoing program of rights realisation for children: 'the task of protecting children adequately from all forms of violence, including corporal punishment, is an ongoing endeavour. Prohibition of corporal punishment is a move towards the broader recognition of children's rights.'[886]

6.1.2 Change attitudes and norms

There is a need for governments in Australia to invest in strategies to change the socio-cultural attitudes and norms that drive restrictive practices alongside all other forms of violence, abuse, neglect and exploitation of people with disability.

As established across Chapters 2, 3, and 4 of this report, restrictive practices are driven by and occur within an ecological system that positions people with disability as lesser, and as naturally unequal to people without disability. This positioning was captured well in the following statement by a person with psychosocial disability in Chapter 2:

> Who cares, he's only a psych patient, who gives a crap. And that's the way it felt. You literally just get de-humanised and it's sort of that once you have become part of that system you do become almost, well not completely, but treated in a sub-human way.[887]

It is also evinced in all other accounts in that chapter of people with disability being treated in cruel, humiliating, inhumane ways that would not be acceptable if they happened in relation to someone without a disability. As Chapters 3 and 4 elaborated, this ableist positioning of people with disability as lesser, and as naturally unequal to people without disability, is often interlinked with law, and the lack of legal response to the harms that have been perpetrated against people with disability, as well as intersectional oppression.

As discussed in Chapter 1, CRPD places strong obligations under Article 5, 12 and 13 to prohibit discrimination and ensure equality before the law and equal access to justice. Further CRPD stresses that people with disability are owed equal rights to protection from violence, as articulated by Articles 14-17 of the Convention. These rights to protection from violence oblige States to take 'all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment' and further 'to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse.' Steps taken to change socio-cultural attitudes and norms are also consistent with 'awareness raising' obligations described by Article 8 CRPD, which extend to activities by States and society to 'combat stereotypes, prejudices and harmful practices relating to persons with disabilities.'

Investment in strategies to change socio-cultural attitudes and norms that drive restrictive practices and other forms of violence, abuse, neglect and exploitation of people with disability would be consistent with contemporary approaches to violence prevention. Changing norms and attitudes is, for instance, a central pillar of global and national efforts to eliminate violence against women. In that context, there is strong recognition that while prohibition of sexual and domestic violence is a necessary step towards ending violence against women, it is not sufficient, and needs to be integrated into a multicomponent strategy that includes changing attitudes and norms that 'normalise' violence against women.[888] Here it is understood that while law plays an important symbolic role in eliminating violence – that is, law produces and/or reinforces social norms and attitudes towards violence against women,[889] with weak

laws potentially seen as condoning said violence[890] – there is a need to ensure that the symbolic role of law works symbiotically with other challenges to the socio-cultural norms and attitudes that sustain violence against women.[891]

An example of how socio-cultural norms and attitudes that sustain violence against women have been challenged in the school context is provided in Case Example 3: Respectful Relationships Education in Schools whole-of-school approach. This approach was adopted by the Victorian Government following the findings and recommendations of the Victorian Royal Commission into Family Violence. That Royal Commission made clear that 'for there to be a reduction in rates of violence in the long-term, attitudes and behaviours must change, and school-based programs and culture can drive this change for young people'.[892] In the context of restrictive practices, we are reminded of a quote first provided in Chapter 2 of this report, where a parent noted:

> My child has witnessed another child being kept in a restraint thereby appearing to normalise this behaviour. Whether you're in the restraint or looking at someone else who is restrained, (it) has an impact.[893]

The Respectful Relationships Education in Schools whole-of-school approach operates in a broader context of legal prohibition of sexual, indecent and physical assault.

Case Example 3: Respectful Relationships Education in Schools

The Respectful Relationships Education in Schools whole-of-school approach focuses on creating broader cultural and social changes within schools to help address the drivers of gender-based violence and break gendered norms that perpetuate violence against women. The approach is premised on an understanding that 'schools are not only educational institutions, but also workplaces and community hubs'.[894] Accordingly, the 'whole-of-school' approach does not just engage students, but also staff, families and the wider school community.

The Respectful Relationships Education in Schools whole-of-school approach is weaved into 'curriculum, school policy and practices, school culture and ethos, the working conditions and culture experienced by staff, and the relationships modelled to students by their school community, including staff, parents, guardians and community groups'.[895] There are seven core elements of respectful relationships education:

1. Address the drivers of gender-based violence.[896]
2. Take a whole-of-school approach to change.[897]
3. Support change by developing a professional learning strategy.[898]

4. Use age-appropriate curriculum that addresses drivers of gender-based violence.[899]
5. Sustain and commit to change by having a long-term vision, approach and funding.[900]
6. Support through cross-sectoral collaboration and coordination.[901]
7. Evaluate for continuous improvement.[902]

In 2020, an evaluation of respectful relationships in primary schools was completed. The evaluation found that after only six months of teaching age-appropriate, gendered content to Years 1 and 2, these students' 'stereotypical gender attitudes regarding jobs and activities showed signs of diminishing'.[903] The evaluation further found that staff in a number of schools 'developed signs of having new insights into gender inequality and the ways in which it impacts on school culture'.[904]

6.1.4 Acknowledge and address historical and ongoing injustice

Restrictive practices represent an egregious systematic violation of the rights of people with disability. Elimination of restrictive practices requires commitment to a process which acknowledges that society and law have perpetrated a historical and ongoing injustice against people with disability. This connection between historical and ongoing injustice was aptly captured in the following account provided in Chapter 2 by a woman with disability who was forcibly sterilised when they were younger:

> If they'd told the truth and asked me, I would have shouted 'No!' My sterilisation makes me feel I'm less of a woman when I have sex because I'm not normal down there ..... When I see other mums holding their babies, I look away and cry because I won't ever know that happiness.[905]

Additional to strategies to change socio-cultural attitudes and norms that drive restrictive practices and other forms of violence, abuse, neglect and exploitation of people with disability which will prevent restrictive practices into the future, is the need to look back and have structural responses of truth and repair to those who have already experienced restrictive practices. These structural responses must engage professions (e.g., medical, health, education, social work and law), services and the broader public in learning about the harms and injustices of restrictive practices, and in reckoning with, and being accountable for, meaningful change. These responses are particularly important in relation to historical injustice, which has a lasting impact, and can have intergenerational impacts on families and communities and continues to shape structural conditions in the present.[906] Such responses can be understood in terms of truth and repair.

As indicated in the introduction to this chapter, truth-telling is one of the key components in a transitional justice approach. Truth-telling refers to 'testimonies by witnesses, victims, and offenders'.[907] Truth-telling can occur through official truth commissions.[908] Other methods include government inquiries, public history studies, artworks, theatre performance, memorials, and sites of conscience. The truth pillar is underpinned by the right to truth about gross human rights violations and serious violations of human rights law. Truth is often understood as a preliminary step in transitional justice processes because it can facilitate a shared awareness and understanding of the past and a reliable evidential basis to facilitate judicial processes, reparations and institutional reform.[909] It can also inform the delivery of reparations that are directed towards maintaining public awareness of historical injustice – 'satisfaction' – those forms of reparations such as public apology or commemoration.[910] Truth-telling provides opportunities for individual healing and moral repair of broken social relations within communities, including through opportunities for the wider community to learn from victim-survivors and reassess both their understanding of the 'truth' of restrictive practices and their accepted moral, professional or ethical values about restrictive practices.[911] This is particularly significant given the broader impacts of using or witnessing use of restrictive practices on people without disability and the long period that restrictive practices have been lawfully, clinically and socially acceptable conduct. Victim-survivor participation is central to truth-telling processes, permitting the recuperation of victim-survivors of gross human rights violation into humanity and community, and restoring fractured social relations.[912] In his report for the Disability Royal Commission on truth-telling in relation to First Nations peoples with disability, Scott Avery describes the importance of truth-telling to the empowerment and self-determination of First Nations peoples with disability:

- The statements of strength and hope embodied within "something stronger" that emerged from a place of entrenched disempowerment are a turning point in the narrative surrounding the violence that affects the First Nations disability community.
- Aspirations of giving 'voice' and empowering others are effectively statements of sovereignty and self-determination, even though that language was not explicitly used.
- Taken as a whole, the community narrative points to a progression from trauma to healing, with empowerment and the self-determination of a connected and inclusive First Nations disability community the end destination.[913]

There are international examples of truth-telling in relation to institutionalisation of people with disability and practices within disability institutions such as restrictive practices (see Case Example 4 below). Acknowledgement of past wrongs and truth telling are important steps towards addressing historical and ongoing injustice. But there are additional steps that might be taken, such as memorialisation, which provide an opportunity to remind the community of past wrongs and instruct younger generations about the injustices of the past.[914] In addition, redress is an important way to provide justice in relation to historical wrong: we discuss redress further below at 6.4.2.

Case Example 4: Truth-telling and People with Disability: Massachusetts, United States of America

In February 2021, a bill was simultaneously introduced in the House and the Senate of the Massachusetts legislature entitled *An Act establishing a commission on the history of state institutions for people with developmental and mental health disabilities in the Commonwealth*. The bill was referred to the Joint Committee on Mental Health, Substance Use and Recovery.[915] Following a series of extensions, in June 2022 the committee reported favorably on the bill, and it was referred to the Health Care Financing Committee.[916] The Health Care Financing Committee then referred the bill on 11 July 2022 to the Senate which ordered investigation into funding the commission at the core of the bill.[917]

In June 2022, key language from the legislation was proposed as a Senate amendment to the fiscal year 2023 state budget. This included a funding proposal that 'not less than $145,000 shall be expended for a special commission on the history of state institutions including, but not limited to, the history of the Walter E. Fernald State School and the Metropolitan State Hospital'.[918]

The legislation was adopted as an outside amendment by the Senate and successfully reconciled into the combined budget submitted to the Governor by the full legislature on June 18, 2022.[919] On 28 July 2022, the commission was funded as part of the 2023 fiscal year budget.[920] However, the bill creating the commission is yet to be passed.

The legislation proposes the establishment of 'a special commission to study and report on the history of state institutions for people with developmental and mental health disabilities in the Commonwealth', and the functions of the commission are:

'(1) review existing records in the possession of the commonwealth from, and related to, the network of state institutions for people with developmental disabilities and mental health issues; (2) examine the current availability of, and barriers to, accessing those records for former residents, their descendants, relatives, and the general public; (3) assess the quality of life of former residents now living in the community; (4) assess and compile records of burial locations for all residents who died while in the care of the commonwealth, (5) determine the likelihood and possible location of unmarked graves at former state institutions (6) present a human rights framework for public recognition of the commonwealth's guardianship of citizens with disabilities throughout history, including recommendations for memorialization and public education; (7) collect testimonials from former residents of state institutions as part of a human rights report (8) and submit its findings and recommendations to the secretary of the commonwealth, the clerks of the senate and the house of representatives, the chairs of the joint committee on children families and persons with disabilities not later than January 1, 2023.'

The report will then be made publicly available.[921] The Bill comes in the wake of longer-term public history projects engaging high school and university students in researching the histories of former institution residents buried in unmarked graves[922] and a protest by local disability advocacy organisations to stop an annual Christmas lights display on the grounds of a former disability institution.[923]

6.2 Institutions: Addressing institutional drivers of restrictive practices

As Figure 9 at the start of this chapter indicates, many of the drivers for restrictive practices occur at the 'institutional' level, in segregated and congregated settings where the concerns of the workplace and worker may be prioritised over the rights and needs of people with disability. To address these institutional drivers of restrictive practices we recommend two core, connected actions be undertaken: deinstitutionalisation and desegregation of people with disability.

Article 5 of CRPD provides for the right to equality and non-discrimination:

1. States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.
2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.

Article 19 of CRPD obliges States Parties like Australia to recognise the equal right of people with disability to live and have full inclusion and participation in the community, with choices equal to others, including by ensuring that:

a. Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
b. Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
c. Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

As implied in Articles 5 and 19, people with disability residing within the community on an equal basis with others, and the inclusion and participation of people with disability in the community on an equal basis with others are interlinked. To this end, our recommendations for deinstitutionalisation and desegregation are also interlinked.

6.2.1 Deinstitutionalise and desegregate

Throughout this report we have noted the way in which institutionalised and segregated settings have contributed to use of restrictive practices. Eliminating restrictive practices thus means that governments in Australia must commit to *full* deinstitutionalisation and desegregation of the living environments of people with disability.

The term 'deinstitutionalisation' is often associated with closure of large residential settings. However, simply closing these settings is not enough to facilitate the future absence of congregated, segregated and coercive living arrangements for people with disability. Put differently, deinstitutionalisation does not involve moving people with disability from large residential centres to smaller scale accommodation which still congregates people with disability, segregates them from people without disability, and does not facilitate them exercising of choice in their living arrangements and their bodies and lives. Indeed, As discussed in Chapter 4 of this report, the research literature is unequivocal: people with wdisability are subject to greatest use of restrictive practices in segregated and congregated settings and environments, including within community-based congregated and segregated residential and care settings, such as group homes and residential aged care facilities, which remain marked by institutional power-dynamics.

Research indicates that to facilitate full deinstitutionalisation of people with disability, there must be a commitment to deinstitutionalisation,[924] a change in attitudes towards people with disability,[925] community development that enables full inclusion and participation of people with disability,[926] as well as a rights-based[927] and *transformative* policy shift towards housing.[928] While it is beyond the scope of this report to outline in detail the steps that must be taken to achieve deinstitutionalisation, and of course, such steps must be guided by people with disability themselves, below in Case Example 5 we describe one strategy to achieve inclusion and participation of people with disability. Here, we focus on one of the core propositions that have been proposed in relation to the identified need for a rights-based, *transformative* policy shift towards housing.

Case Example 5: Housing Policy and Deinstitutionalisation

In focusing on a *transformative* policy shift towards housing that will facilitate the deinstitutionalisation and inclusion of people with disability, we can take guidance from the best practice approaches of European countries. In that context, this policy shift involves creating a division between housing and support policies for people with disability, such that 'the organisation of support and assistance for people is not determined by the type of building they live in'.[929] Instead, it is proposed that organisation of support and assistance for people be assessed by undertaking a 'radical housing' initiative,[930] which emphasises housing first.

While the proposition to emphasise housing first may appear to replicate the problem of merging housing and support policies for people with disability, the following quote taken from a report prepared for the Disability Advisory Council of Victoria clarifies a fundamental distinction:

'Emphasising housing first creates circumstances more like those experienced by the rest of the community. Starting with housing means an initial consideration of modification and adaptation, housing design, assistance for rental or purchase, and then the provision of adequate support. When support services are the starting point, appropriate and typical housing is not the emphasis and there are discussions about economies of scale achieved through group approaches and sharing of support.'[931]

With the rollout of the NDIS, housing and support services are, in theory, separable in the Australian context. However, the reports by the Joint Standing Committee on the National Disability Insurance Scheme indicate barriers remain. Barriers include: a lack of housing options due to 'cost, disadvantage or discrimination in competition for private rental properties, and a limited supply of 'accessible' housing';[932] 'an unknown, but significant, number of people with disability experiencing homelessness' who 'may not be accessing the NDIS or may be struggling to meet access requirements';[933] and, tensions between the NDIS and state-based housing services.[934] The Joint Standing Committee has made numerous recommendations for Australian governments to address these issues. Notably, advocates have also highlighted that some people with disability living in group home settings might have other aspects of their life – such as transport and employment supports – provided by the same NDIS provider, thus replicating the institutional model.[935]

In addition to a focus on deinstitutionalisation, there is also a need to address segregation of environments that people with disability find themselves within. In the context of this report, desegregation means ending segregation in systems that currently only apply to people with disability such as 'special' or segregated schools, Australian Disability Enterprises (ADEs), group homes, day centres, and mental health facilities. As discussed in Chapter 4, segregation of people with disability in these contexts is often 'largely unquestioned and tacitly accepted'.[936] Desegregation would also mean ending segregation that occurs *within* so-called 'mainstream' settings, such as in schools and aged care settings, recognising that segregation in these settings is typically facilitated through use of restrictive practices (e.g., seclusion), as was well illustrated in the account by a parent provided in Chapter 2:

> One parent verbally stated that other students referred to the segregated fenced yard at their daughter's school as the "retard cage".[937]

Ending segregation of people with disability would align with violence prevention and safety enhancement approaches identified in the Royal Commission into Institutional Responses to Child Sexual Abuse. In the Final Report of that Royal Commission, it was stated that avoiding segregation was a key element of how Australian governments and communities can make educational, health and religious institutions child safe.[938]

As was the case with deinstitutionalisation outlined above, desegregation is not a straightforward process, and cannot be separated from broader actions taken to change the socio-cultural norms and attitudes surrounding people with disability. Indeed, as research undertaken into the racial desegregation processes undertaken in the United States of America, South Africa, and parts of Europe has consistently found, desegregation efforts are only ever as equitable as the socio-political contexts within which they occur.[939] As noted earlier, in light of the importance of the right to non-discrimination and equality for people with disability, we should not set a lower standard of what is possible in relation to preventing and responding to violence against people with disability. We should expect that if we can deliver desegregation for other marginalised populations, we can also deliver desegregation for people with disability.

In late 2020, Disabled People's Organisations Australia released a position paper outlining six key actions to end segregation in Australia. We have included these six key actions for ending segregation of people with disability in Australia in full in the breakout box below (Case Example 6).

Case Example 6: Six proposed actions for ending segregation in Australia provided by representative Disabled People's Organisations

1. In line with the CRPD and the general comments from the CRPD Committee, ensure that the human rights model of disability and the principle and standard of equality and non-discrimination underpin the development, implementation and review of law, policy and practice frameworks, including by providing training and guidance to policy makers and legislators at all levels of government and within all portfolio areas, to law reform bodies, to the Parliamentary Joint Committee on Human Rights and to the National Disability Insurance Agency (NDIA), the NDIS Commission and the Disability Royal Commission.
2. In all areas of its work, the Disability Royal Commission must explicitly recognise and conceptualise the segregation of people with disability as discrimination, that segregation is an underpinning enabler of violence, abuse, neglect and exploitation, that segregation constitutes systemic neglect and exploitation; and the Disability Royal Commission must hold governments and other stakeholders to account for supporting, maintaining and funding segregated systems.
3. In line with the CRPD and the general comments from the CRPD Committee, and in close consultation and active participation of people with disability through their representative organisations, Australia should review and amend existing law, policy and practice frameworks for potential or actual support and/or funding of the segregation of people with disability or limitations on their autonomy, including mental health laws and systems, guardianship laws and systems, the NDS, the NDIS Act, NDIS policy and practice and NDIS Commission policy and practice.
4. In line with the CRPD and other international human rights treaties to which Australia is a party, and in close consultation and active participation of people with disability through

their representative organisations, Australia should recognise the legacy of inequality and discrimination, including the segregation of people with disability, by reviewing and taking action to eliminate this segregation, including by developing and implementing:

a. a national, time bound Disability Employment Strategy aimed at the transition of workers with disability from segregated employment to open, inclusive and accessible forms of employment and that ensures equal remuneration for work of equal value; that incorporates recommendations from previous employment inquiries, such as the Willing to Work Inquiry; and that contains targeted gender, age and culturally specific measures to increase workforce participation and address structural barriers.

b. a national, time bound Deinstitutionalisation and Disability Housing Strategy aimed at closing institutional living arrangements for people with disability; preventing the building of new institutional living arrangements, including the building of new group homes through NDIS Specialist Disability Accommodation (SDA); repurposing existing group homes into genuine community-based housing options; providing resources to increase the supply and range of accessible social and public housing stock; and amending the National Construction Code to mandate minimum universal accessible housing design standards for all new and extensively modified housing.

c. a national, time bound Action Pan for Inclusive Education aimed at establishing a nationally consistent legislative and policy framework that fully complies with the CRPD; that adopts a definition of inclusive education consistent with general comment No.4; that reverses the increasing rate of segregated education; that redirects resources to an inclusive education system; that recognises the denial of reasonable adjustment as unlawful discrimination; that contains measurable actions and accountability mechanisms for transition from segregated education to inclusive education; and that prohibits the use of restrictive practices in schools.

5. In line with the recommendations made to Australia since 2013 by the CRPD Committee and the general comment on article 12, Equal recognition before the law, Australia needs to accept that formal and informal substitute decision-making mechanisms are not compliant with the CRPD and that these mechanisms must be replaced with fully supported decision-making mechanisms. To this end, Australia should withdraw its interpretative declaration on article 12 that maintains that the CRPD allows supported or substituted decision-making, and implement a nationally consistent supported decision-making framework.

6. The National Disability Research Partnership (NDRP) must ensure that the development of a national disability research agenda is strongly underpinned by the CRPD, including explicit recognition of segregation as a form of discrimination and substitute decision-making as a denial of individual autonomy; and provide a comprehensive agenda that is not limited to existing service system improvement [940]

6.3 Relationships: Addressing the relationship drivers of restrictive practices

As Figure 9 indicates, when we look at the relationship between dynamics present in the ecological system of restrictive practices – which drive their use – these dynamics are characterised by institutional and uneven relationships of power. To address these relationship dynamics, we recommend the following two core actions be undertaken.

6.3.1 Recognise the autonomy of people with disability

Elimination of restrictive practices requires that governments in Australia respect and protect the autonomy of people with disability to make decisions about what happens to their bodies and lives. This demand for autonomy is consistent with obligations outlined in the CRPD, particularly Article 12 on equality before the law, and Article 19 on independent living and community inclusion, as well as Article 21 on freedom of expression and opinion, Article 29 on participation in political and public life, and general principles in Article 3 of '[r]espect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons' and '[f]ull and effective participation and inclusion in society'.

Chapters 2 and 3 highlighted the lack of agency and dignity given to people with disability through restrictive practices. As a person with psychosocial disability put it in Chapter 2: '[I] Felt lost, completely lost, game over'.[941] Moreover, Chapter 3 further showed how the only way that some people with disability are currently able to ensure some level of 'protection' from traumatic and life-altering harms of institutional uses of restrictive practices, is by limiting their lives further. For example, parents of children with disability might decide not to enrol their children in school if the expectation is their children can only attend school if they are subjected to restrictive practice. Likewise, an adult with disability might decide not to partake in services where they might be at risk of being subjected to restrictive practices.

The recommendation for autonomy is proposed at a few scales. At the most acute scale relevant to restrictive practices, people with disability must have autonomy to make decisions about what happens to their bodies and lives. Legal systems and service systems must facilitate autonomy. Legislation and court jurisdictions enabling substituted decision-making must be replaced with those that are not disability-specific and additionally enable supported decision-making. Service and health systems need to be educated and resourced to implement supported decision-making. Piers Gooding defines 'supported decision-making' as demands centred on 'boosting the agency of persons with disabilities, offering them resources for making choices among good options about how to live', and as taking various forms including 'systems of mutual aid and peer support developed in parallel to state-based services', and 'statutory arrangements for appointing decision-making assistants'.[942] The United Nations Committee on the Rights of Persons with Disabilities, in its General Comment on Article 12 has explained that supported decision-making requires abolition of substitute decision-making and introduction of a supported decision-making regime:

> States parties' obligation to replace substitute decision-making regimes by supported decision-making requires both the abolition of substitute decision-making regimes and the development of supported decision-making alternatives. The development of supported decision-making systems in parallel with the maintenance of substitute decision-making regimes is not sufficient to comply with article 12 of the Convention.
>
> A supported decision-making regime comprises various support options which give primacy to a person's will and preferences and respect human rights norms. It should provide protection for all rights, including those related to autonomy (right to legal capacity, right to equal recognition before the law, right to choose where to live, etc.) and rights related to freedom from abuse and ill-treatment (right to life, right to physical integrity, etc.). Furthermore, systems of supported decision-making should not over-regulate the lives of persons with disabilities.[943]

The Committee has explained that supported decision-making regimes should include the following aspects:

> (a) Supported decision-making must be available to all. A person's level of support needs, especially where these are high, should not be a barrier to obtaining support in decision-making;
>
> (b) All forms of support in the exercise of legal capacity, including more intensive forms of support, must be based on the will and preference of the person, not on what is perceived as being in his or her objective best interests;
>
> (c) A person's mode of communication must not be a barrier to obtaining support in decision-making, even where this communication is non-conventional, or understood by very few people;
>
> (d) Legal recognition of the support person(s) formally chosen by a person must be available and accessible, and States have an obligation to facilitate the creation of support, particularly for people who are isolated and may not have access to naturally occurring support in the community. …;
>
> (e) … ensure that support is available at nominal or no cost to persons with disabilities and that lack of financial resources is not a barrier to accessing support in the exercise of legal capacity;
>
> (f) Support in decision-making must not be used as justification for limiting other fundamental rights of persons with disabilities, especially the right to vote, the right to marry, or establish a civil partnership, and found a family, reproductive rights, parental rights, the right to give consent for intimate relationships and medical treatment, and the right to liberty;

(g) The person must have the right to refuse support and terminate or change the support relationship at any time;

(h) Safeguards must be set up for all processes relating to legal capacity and support in exercising legal capacity. The goal of safeguards is to ensure that the person's will and preferences are respected.

(i) The provision of support to exercise legal capacity should not hinge on mental capacity assessments; new, non-discriminatory indicators of support needs are required in the provision of support to exercise legal capacity.[944]

Enhancing the autonomy of people with disability in relation to First Nations peoples with disability needs to be understood in the broader context of Indigenous and First Nations self-determination and nation-building. Scott Avery argues that enhancing self-determination of Aboriginal and Torres Strait Islander peoples with disability, including their access to culture and Country, should be central to strategies, support mechanisms and policy in relation to people with disability. Avery details experiences of discrimination experienced by disabled First Peoples in the non-Indigenous Australian community and contrasts this with the positive, strengths-based and humane reception of disability in Aboriginal and Torres Strait Islander culture and the importance of culture to improving wellbeing.[945] Indeed, Avery argues that Aboriginal and Torres Strait Islander disabled people enjoy similar levels of access to culture as non-disabled Indigenous Australians.[946] Avery proposes 'an Indigenous cultural model of inclusion' that 'seeks to improve the human condition through positive affirmation, as distinct to merely negating the adverse impact of difference' by 'fostering social inclusion, through the active participation in community and cultural activities'.[947] Avery notes, however, that 'the status of the research is not sufficiently advanced to be prescriptive on how this translates into policy and practice' and that the 'model of cultural inclusion is presented as a vision and direction for a future Aboriginal and Torres Strait Islander disability research agenda' that, in time, can inform policy and practice.[948] 'Self-determination', as an aspect of a pathway to elimination, needs to be interpreted beyond individualised autonomy over one's body to a broader notion of collective autonomy over land, culture and community. This more expansive approach to self-determination is reinforced by the United Nations Declaration of the Rights of Indigenous Peoples.[949]

6.3.2 Utilise trauma informed support approaches

Chapter 2 of this report highlighted the traumatic effects of use of restrictive practices for victim-survivors: 'I felt violated … I felt everything had been stripped from me … I felt ashamed.'[950] Further, all people with disability, whether or not they are subject to the use of restrictive practices, are more likely to experience violence, abuse, neglect and exploitation compared to other members of the community. As such, there is a need for governments in Australia facilitate trauma-informed approaches to service-delivery, particularly within the human services sector.

This recommendation is consistent with the obligations outlined in Article 16 of the CRPD, which states in part that:

> States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive. […]
>
> 4. States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.

Chapter 2 of this report provided numerous accounts of the traumatic, lifelong and life-altering effects of restrictive practices on people with disability. That chapter articulated the ways that the trauma of being subject to restrictive practices can extend beyond the immediate moment or moments when violence, harm, pain and suffering are being perpetrated and experienced, and into the future of the person with disability.

Such findings coincide with national and international research which recognises that many people who seek or who are referred to the human services sector are victim-survivors of cumulative, underlying psychological and emotional trauma.[951] Common to this body of research on trauma are the evidence-based understandings that: (a) human services can be re-traumatising for people who have 'complex' (i.e. cumulative, underlying) trauma, and (b) complex trauma can be addressed.[952] To this end, there has been growing call for and investment in 'trauma-informed' approaches, and more broadly, 'trauma-informed' service systems.[953] In Case Example 7 below, we summarise the practice guidelines for treatment of complex trauma and trauma informed care and service delivery that were produced by the Blue Knot Foundation (formerly, Adults Surviving Child Abuse) for the Australian Government Department of Health and Ageing.[954] These guidelines were officially recognised as an 'Accepted Clinical Resource' by the Royal Australian College of General Practitioners, and have received national and international endorsements from key bodies.

Notably, the benefits of 'trauma-informed' approaches and service systems has only very recently been considered in the context of people with disability and disability services. Indeed, much of this body of literature on disability services and trauma-informed approaches has only been published within the last two years, although literature concerning mental health settings has been published in the last decade. This only recent consideration of 'trauma-informed' approaches and service systems in the disability sector has occurred despite the potential benefits of taking a 'trauma-informed' approach to disability and mental health

service systems being recognised almost two decades ago.[955] Research concerning 'trauma-informed' approaches to disability service systems has found that perceived 'behaviours of concern' by people with disability 'may be the manifestation of coping strategies' associated with traumatic experiences,[956] with some studies indicating that taking a trauma-informed approach to service delivery may reduce staff use of restrictive practices.[957] Such findings, while only in their infancy, are reflective of those presented in Chapter 3 of this report.

Crucially, the emerging disability-focused body of work on trauma and trauma-informed approaches has concluded that the effectiveness of trauma-informed approaches performed by carers and service providers will remain questionable unless the underlying systemic and structural drivers that enable carers and service providers to perpetrate violence, abuse, neglect and exploitation of people with disability are addressed.[958] In the context of this report, this finding suggests that the under-resourcing and under-staffing of services and supports for people with disability must be addressed. It also means that a trauma-informed approach to use of restrictive practices is impossible, and that service delivery can only be trauma-informed if restrictive practices are prohibited from being used.

Case Example 7: Practice Guidelines for Trauma-Informed Care and Service-Delivery produced by the Blue Knot Foundation (Formerly Adults Surviving Child Abuse)

Philosophy & Vision

1. Establish service-charters of trauma-informed care which recognise the prevalence and impacts of unresolved trauma, and how trauma can be reproduced in social institutions and settings; and which stipulate that 'no aspect of service-deliver (direct or indirect; practice, infrastructural or administrative) should be exempt from requirements to comply with trauma-informed principles'.[959]
2. Explicitly commit within the service-charter to a recovery orientation, such an orientation needs to be predicated on five foundational principles of trauma-informed care – 'safety', `trustworthiness', `choice', `collaboration' and `empowerment' – and requires a shift in perspective and practice: from 'what's wrong with you?' to 'what happened to you?'[960]
3. Promote understanding of the impacts of trauma and the importance of coordinated care.[961]
4. Commit to survivor/consumer driven systems at all levels, which would involve respecting and being attentive to lived experience.[962]
5. Commit to all forms of diversity, which would involve respecting and being attentive to intersectionality.[963]

6. Incorporate a message of optimism and hope about resolution of trauma into all interactions between service-providers and clients.[964]

Mapping to practice: System Level

1. Promote collaboration and coordination between and among systems of care (i.e., health, social services, education, and criminal justice systems), and incorporate a life-span perspective that recognises intergeneration of trauma.[965]
2. Revise all policies and procedures to incorporate trauma-informed principles and monitor compliance with these principles over time.[966]
3. Involve consumers in all systems and articulate and uphold trauma-informed rights (e.g., rights to trauma treatment, freedom from re-traumatisation).[967]
4. Review education, training, and ongoing professional development to incorporate trauma-informed principles for all employees, volunteers, board members and stakeholders.[968]
5. Identify funding requirements necessary to operationalise the envisioned changes in service culture.[969]
6. Promote education in trauma through intersectoral collaboration with institutions of learning such as universities, colleges, and training organisations.[970]
7. Respect diversity, including by being attentive to how 'bias affects and is registered by others'.[971]

Mapping to practice: Service Level

Step 1: Identify key formal and informal activities and settings, which may also include identifying staff members involved in these activities and settings.[972]

Step 2: Ask key questions about each of the activities and settings, including 'how do they currently operate and how might they operate differently according to principles which are trauma-informed?'[973]

Step 3: Prioritise goals for change, which may include considering: feasibility, resources, system support, breadth of impact, quality of impact, risks and costs of not changing, among other considerations relevant to the specific organisation.[974]

Step 4: Identify specific objectives – with measurable outcomes and timelines – as well as responsible persons.[975]

6.4 Addressing individual drivers of restrictive practices and providing equal access to justice and remedy

As Figure 9 indicates, core to the individual dynamics present in the ecological system of restrictive practices, and which drive their use, are the communications of people with disability about unmet support needs which are misinterpreted as 'behaviours of concern'. To address this dynamic, we recommend two core actions be undertaken.

6.4.1 Adequately resource independent living and full inclusion

> They [staff] never specified any time limit that I should be in there. When day staff came back on I was let out, there was no reason that I was let out then and not six hours before, it was just convenient for them [staff] and that's wrong.[976]

> I sign permission for [name removed] to have a seatbelt on his wheelchair, expecting it to be used only when he is in transit. I am assured that it will not be left on him all day, but every time I go to see him, at different times every day, he is strapped down. It looks like the staff, at each new shift, just leave him as they find him. He is trussed tightly around his legs and body, the strap in the middle biting deeply into him. This makes it extremely difficult for me to take him to the bathroom, or for him to eat at table. He has no exercise, and his mobility is affected. He is constantly agitated, asking me and others to set him free.[977]

Chapters 2, 3, 4 and 5 of this report articulated the multiple ways that people with disability's rights and needs are not being met at this time. These chapters also showed how restrictive practices are commonly used in these environments where rights and needs remain unmet. Indeed, these chapters showed how restrictive practices can be used against people with disability who are communicating a necessity to meet their unmet needs, with these expressions of unmet needs misinterpreted as 'behaviours of concern' in what are instead legitimate forms of communication in response to 'environments of concern'. These chapters also showed how restrictive practices do not respond to a person with disability's needs, and thus when they are used against people with disability, the needs of the person remain unmet. As such, this report finds that there is a need for governments of Australia to ensure accountability of individuals and service providers responsible for these 'environments of concern' and adequately resource the people with disability to enable independence and full participation. Realising these rights of people with disability will help to reduce or remove the circumstances of inequality, control, coercion, segregation, and confinement that are drivers of and form part of the ecological system of restrictive practices, and enhance their overall status in society. Further, as indicated above, within the context of existing forms of institutionalised treatment, instruments such as OPCAT provide one avenue to pursue elimination through monitoring.

As discussed in Chapter 1, Article 19 CRPD provides a clear vision for enabling independent living a community inclusion for people with disability. The Article blends so called 'negative' rights entitlements to freedom of movement and freedom from arbitrary detention with 'positive'

obligations to fully resource supports to enable people with disability choice and control over living environments and full inclusion within society. The UN Committee on the Rights of Persons with Disabilities has explained that being included in the community includes:

> living a full social life and having access to all services offered to the public and to support services offered to persons with disabilities to enable them to be fully included and participate in all spheres of social life. These services can relate, among others, to housing, transport, shopping, education, employment, recreational activities and all other facilities and services offered to the public, including social media. The right also includes having access to all measures and events of political and cultural life in the community, among others, public meetings, sports events, cultural and religious festivals and any other activity in which the person with disability wishes to participate.[978]

These rights interconnect with 'economic, social and cultural rights', articulated in the UN International Covenant on Economic Social and Cultural Rights (ICESCR) also articulated in CRPD directly in rights to education (Article 24), health (Article 25), habilitation and rehabilitation (Article 26), work and employment (Article 27), adequate standard of living and social protection (Article 28), and participation in cultural life and recreation (Article 30).

Article 19 and the interdependence of economic, social and cultural rights highlights that elimination of restrictive practices must go beyond simply prohibiting infringements of civil liberties, and move towards enabling and positively supporting equal flourishing for people with disability. As McSherry has noted, this requires an approach which 'moves beyond a focus on negative rights in the sense of freedom from involuntary detention and treatment, to one that emphasises positive rights in requiring States parties to provide the services and supports that are needed to enable persons with mental impairments to become fully functioning members of society'.[979] Indeed, McSherry's observations on the importance of the CRPD's positive rights reflect the Goldblatt's argument about the importance of realisation of economic, social and cultural rights to preventing and responding to violence against women:

> Social and economic rights have potential value in contributing to the prevention of violence […] Together with substantive approaches to equality, social and economic rights might be marshalled to achieve transformative changes to society, by altering some of the structural underpinnings of poverty and inequality that contribute to violence against women. For example, these rights might be used to require governments to employ women in public works programmes that improve their status and economic power in their communities and reduce their vulnerability to violence. […] The complexity of this issue demands a holistic engagement of the full spectrum of rights, premised on the understanding that substantive realisation of all rights may require resource allocation and redistribution.[980]

Full resourcing for independent living and economic, social and cultural rights potentially encompasses a wide-ranging set of questions about the adequacy of social policy arrangements within the context of the Australian welfare state, which might include income support provisions, wage regulation, unemployment benefits and policies,

housing arrangements, and education frameworks. While we have touched on housing policy above in Case Example 8, it is beyond scope of this report to recommend specific measures for social policy reform. However, in Case Study 8 below, we include some relevant policy recommendations from the Australian Council of Social Service (ACOSS), the national advocacy body supporting people affected by poverty, disadvantage and inequality, and the peak council for community services nationally. Recognition of these economic, social and cultural rights, in so far as they promote independence and social and economic participation, would go some way towards addressing the ecological system of restrictive practices.

Case Example 8: The 2022–2023 ACOSS Pre-Budget Submission

The Australian Council of Social Service (ACOSS) is a national body supporting people affected by poverty, disadvantage and inequality, and the peak council for community services. Every year ACOSS produces a submission as part of the Australian Government Treasury Pre-Budget Submission process. The ACOSS 2022-2023 pre-budget submissions includes several recommendations relevant to enhancing the economic and social rights of people with disability.

In relation to revenue, ACOSS note that there is continual pressure on the adequacy of funds to support social protection, including funding for the National Disability Insurance Scheme. Responding to these challenges to revenue base through tax reform will be essential, including through 'reforms to taxes on investment incomes from property and shares, superannuation, the use of private companies and trusts to avoid tax, curbs on tax avoidance by multi-national companies, and the removal of business tax concessions that are economically and environmentally harmful such as fossil fuel subsidies.'[981] ACOSS also notes the need to create policies that prevent taxpayer avoidance of the Medicare levy, which funds health and disability services in Australia.[982]

Enhancements to economic security, relevant to people with disability, are a focus of the submission. For example, ACOSS recognises the need for an ongoing cost of living supplement for people with disability receiving income support payments to ensure a standard of living that is equivalent to other community members.[983] ACOSS also recommended a substantial increase in unemployment ('Jobseeker') payments to equivalise with pension levels.[984] Many people with disability are not eligible for the Disability Support Pension, and / or are unemployed; as such this recommendation would immediately enhance the safety net for people with disability and improve living standards for those who receive income support. It is important to note that these proposals to enhance economic security occur at a moment of intense global debate over the restructure of income support systems, including through the development of Basic Income schemes.[985]

Another focus of the ACOSS pre-budget submission is improvement in access to affordable housing for people on low incomes. ACOSS have recommended a substantial expansion in funding 'to State and Territory governments to facilitate construction of 20,000-30,000 social housing dwellings that meet accessibility and energy efficiency standards.'[986] The submission also includes proposals for a First Nations housing strategy, investment incentives for the construction of affordable rental housing, and increases in Commonwealth Rent Assistance rates.[987] As indicated in Section 6.2.1 above, access to housing is an issue that interconnects with the challenge of deinstitutionalisation. The ACOSS proposals would assist to expand housing supply and promote increased affordability.

6.4.2 Provide redress for victim-survivors

As discussed above, the elimination of restrictive practices requires commitment to a process which acknowledges that society and law have perpetrated a historical injustice against people with disability. This extends to providing forms of just rectification, including redress for victim-survivors. In this section we discuss two different approaches to supporting access to redress – first, through the criminal and civil justice systems, and second through a proposed national redress scheme.

The law is a powerful and important place for trying to achieve justice for people with disability who are subject to restrictive practices. The above proposed immediate legal prohibition of use of restrictive practices on a discriminatory basis against people with disability would undo the identified role the law has played in enabling and legitimising the violence of restrictive practices into the future. There is, however, an additional role the law can play to further undo the harms of restrictive practices. Specifically, people with disability for whom prohibition comes too late because they have already experienced violence, abuse, neglect and exploitation through restrictive practices should be able to obtain redress through criminal and civil justice systems. These avenues for redress are not currently available to people with disability, as aptly explained by Chris, a person with psychosocial disability in Chapter 3:

> yeah, and they won't go to court either [for using restrictive practices …] what they've done is allowed nothing will happen to them they'll keep on, they just doing their job […] well I think it's disgusting.[988]

Courts are seen as an essential forum for redress in society, not least of all because of their independence from the executive, their interpretation and application of legal doctrine in decision-making, the public transparency of their hearings and decisions through the principle of open justice, and their carefully regulated processes. As well as serving individual justice, courts can have a unique role in facilitating structural legal change in at least two ways.

First, courts situate a complaint in a context of public justice. By reason of the principle of 'open justice', court proceedings and decisions are available to the public (either directly through attending court or accessing the published decision, or through media reporting).[989] Generally, justice is delivered publicly and openly in a court so that the judiciary is accountable and the public have confidence in the justice system.[990] Moreover, the public can know what is argued and the evidence on which the courts proceeds. Court judgments can enable public knowledge of injustices, notably those involving the government, corporations, or charities that might otherwise be concealed (particularly in a context where corporations and charities are not principally accountable to the individuals to whom they provide services, and can access public relations and marketing support to conceal or minimise information about injustices).

Second, through its judgments, courts render an interpretation of law that contributes to the development of legal doctrine.[991] As such, court judgments can have the potential for structural reform because decisions in court judgments, through the structure of precedent, can impact on resolution of later matters or at least communicate to and educate the public on appropriate conduct. In contrast, decisions reached by complaint mechanisms and other mechanisms in the executive arm of government are not usually binding and cannot clarify or develop law for application in future cases.[992]

There is little indication that matters concerning violence, abuse, neglect and exploitation through restrictive practices are coming before the courts to a degree that is reflective of the systemic nature of this problem. There are also no clear policies and practices in place within specific systems to facilitate this to occur. For example, as noted in Chapter 5, recent reporting by the NDIS Quality and Safeguards Commission suggests that over a million uses of 'unauthorised' restrictive practices were reported in 2020-2021.[993] Arguably, because these were not 'authorised', each of these instances might constitute criminal offences and civil wrongs such as assault or false imprisonment, and acts of violence for the purposes of state and territory victim support schemes. Yet, neither the NDIS Quality and Safeguards Commission report detailing these unauthorised restrictive practices, nor the subsequent media reporting indicated that individuals had been informed of their legal rights to report the unauthorised restrictive practices to police, take civil action to obtain compensation or other remedies, or apply for counselling and other assistance through victim support schemes, or even that each individual had been informed they had been subject to unauthorised restrictive practices. These concerns about an absence of reported action in response to unauthorised restrictive practices are compounded in relation to people with disability under guardianship, where accessing victims support and legal services might be within the control and responsibility of the guardian. The absence of any framing of the 2020–2021 mass use of unauthorised restrictive practices in terms of justice and redress is a troubling indication of the extent to which people with disability are denied equal access to justice and to a remedy.

It is vital that equal access to criminal and civil justice systems is a key aspect of the pathway to elimination and accommodations must be provided to support access and participation in justice systems. Such an approach aligns with Articles 5, 12, and 13 of the CRPD which together provide for rights to equal access to justice and equal recognition before the law, and access

to accommodations and supports to realise these rights. Moreover, pursuant to Article 8 on awareness raising, there must be programs for community legal education both directed towards people with disability, disability support services, and guardians, concerning the legal rights of people with disability in general, and the specific legal rights of people with disability to remedies for violence, abuse, neglect and exploitation associated with restrictive practices. There should also be community legal education to police, legal professionals and judiciary to raise awareness of restrictive practices as violence, abuse, neglect and exploitation, and how to support people with disability in the justice system in response to these experiences. It is vital for court processes to be accessible and inclusive, and trauma-informed as will be discussed in section 6.3.2 – otherwise these processes can continue the violence, abuse, neglect and exploitation associated with the restrictive practices.

Finally, we note that while equal access to criminal and civil justice systems is a human right, and courts are conventionally understood as the pinnacle forum for individualised justice in Australia, they are not without their limitations.[994] For instance, accessing individual redress in the form of court remedies is dependent on each individual bringing their own civil matter to court (or a class action being brought on behalf of a group of individuals) – even if a precedent is established in relation to restrictive practices, for others to benefit from this legal victory they will similarly need to commence civil legal action. Thus, civil justice systems offer one vehicle for individualised legal justice but are not suited to being the sole form of response to mass and systemic harms such as the decades long, widespread use of restrictive practices.

Therefore, while individual redress through criminal and civil justice systems are an option that should be available to people with disability on an equal basis to people without disability, they might not be the ideal method for responding to individual experiences of restrictive practices that have been perpetrated on a mass scale. It is for this reason this report recommends a second approach to individual redress through the establishment of a redress scheme for people with disability who have been subject to restrictive practices, including people with disability who are no longer living.

The United Nations Committee on the Rights of Persons with Disabilities provides that, in implementing Article 5, States Parties are required to: '[e]stablish accessible and effective redress mechanisms and ensure access to justice, on an equal basis with others, for victims of discrimination based on disability.'[995] Moreover, in the context of violations of the right to liberty, the Committee has stated: 'Persons with disabilities arbitrarily or unlawfully deprived of their liberty are entitled to have access to justice to review the lawfulness of their detention, and to obtain appropriate redress and reparation.'[996] Article 2.3 of the International Covenant on Civil and Political Rights (ICCPR) provides for a right to remedy:

> Each State Party to the present Covenant undertakes:
>
> a. To ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity;

b. To ensure that any person claiming such a remedy shall have his right thereto determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy;

c. To ensure that the competent authorities shall enforce such remedies when granted.

Article 9.5 ICCPR similarly calls for 'an enforceable right to compensation' in relation to unlawful arrest or detention. Article 14.1 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) provides for a right to a remedy for torture:

> Each State Party shall ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible. In the event of the death of the victim as a result of an act of torture, his dependants shall be entitled to compensation.

The Committee against Torture has explained that conduct that amounts to torture or ill-treatment gives rise to a duty to provide remedy and reparation.[997] The right to redress includes restitution, compensation, rehabilitation, satisfaction, guarantees of non-repetition and the right to truth.[998]

In sections 6.1.2 and 6.1.4 we discussed two of the core ways by which redress and repair for people with disability can be facilitated at a structural and societal-level: through justice systems and truth telling. Here we discuss one of the core ways by which redress for people with disability who have been subject to restrictive practices can be facilitated at an *individual-level*: the establishment of a redress scheme. Importantly, before we move forward with this discussion, it is necessary to clarify that the three identified ways by which redress and repair for people with disability can be facilitated are not to be interpreted as interchangeable options. In particular, the design of any redress and repair mechanisms must ensure equal access to justice, including equal access to the justice system such as police and civil and criminal courts, and any new or bespoke redress options must not be a substitute for addressing deficiencies in the existing justice system. It is recommended that each approach is pursued to redress and repair past harms of restrictive practices.

Redress schemes are a fundamental option for individual redress of restrictive practices.[999] Whereas remedies through criminal and civil justice systems are administered by the judicial arm of government, redress schemes are administered by the executive arm of government and are typically constructed by the legislature. This distinction in terms of constitutional status gives rise to at least three fundamental differences in the relationship between the harm and the redress. First, in redress schemes, access to redress is not determined by a judge in the context of a specific cause of action, nor are they dependent on each individual separately proving their experience of harm fits within a particular cause of action. Rather, redress schemes begin from the starting point of recognition both of the existence of a mass harm (such as institutional child sexual abuse, wage exploitation) and that people who experienced this mass harm should be entitled to redress. Access to financial payments and other supports at first instance turns on the facts of an individual's experience against a set of administrative rules as assessed by a

bureaucrat, rather than the application and interpretation of legal doctrine. Second, redress schemes do not have the same evidentiary requirements as in civil litigation, nor subject to the strict limitation periods as civil litigation. Third, access to redress does not necessarily turn on the harm being contrary to law as it does in civil litigation, and can even be introduced in recognition of the fact that harm is incapable of judicial remedy because it was perpetrated lawfully pursuant to discriminatory or otherwise unjust laws that were in force in an earlier social and political context. Stolen Generations reparations schemes operating in Australian states and territories are an example of redressing injustices that were often perpetrated pursuant to legislation.[1000]

For people with disability, a redress scheme can potentially be more accessible, affordable and efficient than court litigation, is capable of making redress available to a larger group of individuals (including those who have experienced lawful restrictive practices or historical restrictive practices), and is not dependent on the present-day existence and/or wealth of the perpetrators. From a human rights perspective, a redress scheme is particularly significant because it can redress all human rights violations irrespective of whether they were unlawful under domestic law. A redress scheme should operate alongside court remedies, and access to one should not prevent access to the other.

In designing a redress scheme that can deliver redress in relation to restrictive practices, it is vital the Government consider some of the limitations in the design or operation of other redress schemes in Australia such as the National Redress Scheme, state and territory Stolen Generations Reparations Schemes, and the Business Services Wage Assessment Tool payment scheme, and identify ways to overcome these in a redressing restrictive practices. These include:

- Individuals have the option of an official, publicly available record of their experiences in a form of their choosing.
- Individuals are not precluded from seeking court redress when they participate in a redress scheme.
- Individuals and DPOs have a role in the design and oversight of the redress scheme, particularly its processes and outcomes.
- A strategy is developed to ensure people with disability in institutional and closed settings and from particularly marginalised groups are informed of and supported in accessing the redress scheme.
- The redress scheme is accessible and inclusive for people with disability.
- The redress scheme does outreach to people with disability in institutional and closed settings such as group homes, prisons and boarding houses.[1001]
- The redress scheme provides resources and education on the scheme to disability services and guardians.

- The redress scheme is culturally appropriate to First Nations peoples with disability, including providing for both individual and collective redress.[1002]
- The redress scheme must be efficient.[1003]
- The redress scheme must be trauma-informed, including not requiring people with disability to re-tell their story of abuse to multiple health professionals and bureaucrats and avoiding processes that involve monetary valuation of the impacts of abuse.[1004]
- The redress scheme must be flexible in its outcomes to respond to the diverse harms and lifelong impacts of restrictive practices.
- The redress scheme must not discriminate based on immigration status or criminal justice history, particularly noting the discriminatory impacts this will have on CALD people with disability and people with disability how have been in the criminal justice system.[1005]
- The redress scheme has a transparent assessment process which includes publicly available assessment guidelines.[1006]
- The redress scheme respects universal legal capacity.[1007]

Moreover, while we focus here on redress specifically for use of restrictive practices (by reason of the topic of this research report), we propose that any redress scheme through which use of restrictive practices are redressed should extend to the full range of violence, abuse, neglect and exploitation of people with disability. This is particularly necessary given restrictive practices is usually interconnected with other violations, particularly when it occurs in the context of segregated or institutional settings. Indeed, this has been one criticism by victim-survivors of the National Redress Scheme only providing redress for institutional child sexual abuse.[1008]

There are already international examples of redress schemes for restrictive practices, specifically in relation to eugenics sterilisation compensation schemes (see Case Example 9 below).

Case Example 9: Three examples of sterilisation compensation schemes

In North Carolina, there is a compensation scheme for survivors of forced sterilisation under North Carolina's Eugenics Board Program 1929-1974. Survivors can access a lump-sum financial payment and mental health services. Additional to the compensation scheme, the Governor of North Carolina has officially apologised, and there is a memorial in the form of a travelling exhibition has been developed to raise broader public awareness about the history of sterilisation.[1009] Similarly, in Virginia, there is a compensation scheme for survivors of sterilisation under eugenics legislation that operated during 1924-1978. The Governor of Virginia has publicly apologised for sterilisation under the eugenics sterilisation legislation.[1010] In 2019, Japan passed a law which provides for apologies and compensation to victim-survivors of sterilisation under the 1948 Eugenics Protection Law, which operated 1949 to 1996.[1011]

6.5 Conclusion

Restrictive practices are deeply entrenched within legal systems, professional practices and disciplinary knowledge, and service practice, and are supported by drivers, an enabler and an entire ecological system. As such it is recognised that ending use of restrictive practices is a necessarily ambitious and large goal and will require ongoing commitment and action rather than piecemeal solutions. Yet, the goal of elimination should not be dismissed as merely aspirational and unachievable. It is often observed that people with disability are the victims of low expectations, and it is vital not to let low expectations define what is possible in the context of violence prevention and restrictive practices. In particular, we must ensure equality and non-discrimination for people with disability and not dismiss the possibility of utilising strategies such as legal prohibition, desegregation, deinstitutionalisation, and redress which have been utilised in relation to other marginalised populations. Thus, in order to support this transformative change, this chapter has outlined an eight-point plan to eliminate use of restrictive practices which recognise (rather than shy away from) the enormity of what is required. This plan is attentive and responsive to these drivers, enabler and ecological system.

Conclusion

This report has provided an evidence-base for understanding that restrictive practices strip people with disability of their dignity, occur in an ecological system of coercion and control, and are driven and enabled by a range of relationships, and institutional and societal dynamics. This evidence-base provides a strong foundation for the finding that restrictive practices have no place in Australian society. In moving forward from this finding, there is a need for support systems and legal systems to be transformed to promote the human rights of people with disability and respond to and prevent their exposure to violence, abuse, neglect and exploitation.

This report is based on a nine-month research project. The objectives and research questions of that project were set by the Disability Royal Commission. In this concluding chapter of the report, we provide summary responses to the four research questions set by the Disability Royal Commission to be addressed through the research project.

RQ1: What are the systemic drivers of the use of restrictive practices against people with disability? How do these differ across settings across Australia?

Research question 1 was addressed across Chapters 3 and 4 of this report to the extent possible within the context of the limits of current research. Here we note that the findings across these chapters primarily relate to disability-specific settings – such as institutional settings, group homes, and psychiatric wards – where restrictive practices are commonly recognised as occurring, and where legislation and policy authorise and regulate the ongoing use of these practices. Chapters 3 and 4 also drew on the small collection of literature concerning drivers of restrictive practices in schools – a setting where it is commonly recognised that restrictive practices occur, but where regulation is often inconsistent or absent. However, there are few, if any, studies currently available that consider the drivers and enablers of restrictive practices either in settings that are not disability-specific, or in contexts where the legal basis for restrictive practices is other than the most well-known laws such as guardianship, disability, mental health and *parens patriae*. Restraint, containment and coercive and non-consensual measures happen in a range of settings. However, research on disability-specific restrictive practices and their impact on people with disability is not always available. Accordingly, there is, almost no literature on restrictive disability-specific practices in out-of-home-care, immigration detention centres, or prisons. What this gap in current research means in practice is that while this report has been able to identify systemic drivers and enablers for use of restrictive practices across a range of different settings, and the report is able to indicate from which setting specific findings about drivers have been found, it is not possible from within the limits of current research to indicate with any specificity how these drivers and enablers differ across settings across Australia.

With the above limitations in mind, in Chapter 3 the report listened to the voices and experiences of people with disability who have been subject to restrictive practices across a range of settings. This conforms with the importance placed by the Disability Royal Commission on ensuring that 'people with disability are central to processes that inform best practice decision-making on what all Australian Governments and others can do to prevent and respond to violence against, and abuse, neglect and exploitation of, people with disability'.[1012] The chapter drew on these voices and

experiences to trace the contours of the concentric circles of relationships, institutions and social structures that envelop and extend out from the person with disability, and which enable violence, abuse, neglect and exploitation to be perpetrated against people with disability through use of restrictive practices. Here it was identified that at the 'Individual' level of the ecological system, there are dynamics such as the unmet needs of people with disability, as well as the distress, protest and resistance of people with disability to maladaptive environments. At the 'Relationships' level, uneven power-dynamics in the relationships between people with disability and those who are empowered to use restrictive practices against them in a range of contexts and settings were identified and explored. These uneven relationships were then located at the 'Institutional' level within an environment where dynamics such as workplace cultures of convenience, silence and secrecy are present. Finally, Chapter 3 identified that at the 'Society' level of the ecological system, there are encompassing socio-legal norms and expectations that enable people with disability to be legally subject to violence, and to receive differential and unequal treatment under law.

Chapter 4 then built on these experiential understandings of the ecological system of restrictive practices, by turning to the broader research literature – which often focuses on the perspectives of practitioners – to explore what has been studied about the systemic drivers and enablers of restrictive practices. That chapter outlined how the drivers and enablers of restrictive practices interact and intersect with one another, and how they produce the experiences and ecological system described by people with disability in Chapters 2 and 3 of the report. To this end, four systemic drivers as well as one core enabler of restrictive practices were identified in Chapter 4:

Driver 1: Segregated and congregated environments where institutional power-dynamics are inherent.

As evinced in Chapter 4, the research literature is unequivocal: people with disability are subject to greatest use of restrictive practices in segregated and congregated environments. As Chapter 4 explained, this use of restrictive practices occurs in part because of lack of choice and autonomy provided to people with disability in these environments and settings, in part because of institutional, uneven power-dynamics inherent to these environments and settings, as well as potentially in part because of other factors not currently identified by research.

Driver 2: Workplace concerns

There are four core workplace concerns that appear to work both separately and together to drive use of restrictive practices.

1. **Experience levels of staff**

   Research indicates that staff who have worked in their role for a long period of time are more likely to use restrictive practices against people with disability. Research suggests that staff with the greatest level of experience on the job may hold the belief that restrictive practices are necessary because 'this is how it's always been'. Research further indicates that more experienced staff can be less willing to change their practices, and feel frustrated when this historically accepted practice becomes less readily available to them.

2. **Institutional cultures of blame and risk management**

Several studies suggest that staff use of restrictive practices is influenced by and occurs within an institutional culture of blame and risk management. This culture contributes to increased preoccupation by staff with risk management, with research showing that staff who uphold traditional, risk-focused, stigmatising and pathologizing beliefs about people with disability being more likely to use restrictive practices.

3. **Occupational health and safety concerns of staff**

Australian research has identified a growing number of organisations which justify increased use of restrictive practices by reference to occupational health and safety concerns of staff. Research suggests that this justification is often based on a pervasive misrepresentation of facts, whereby it is commonly assumed that the occupational health and safety concerns of staff are somehow 'mutually exclusive' to the human rights realisation for people with disability, with the result being, the occupational health and safety concerns of staff often trump the rights of people with disability in a range of settings, including mental health, disability services and education. However, research indicates that some staff also experience psychological, ethical and moral harm from using or witnessing use of restrictive practices, thus undermining their occupational health and safety.

4. **Perceived 'duty of care' obligations**

Perceptions about the duty of care obligations staff hold towards people with disability can both intertwine with staff concerns about their own occupational health and safety, and operate separately to them as another element driving use of restrictive practices. Research suggests that there is some 'confusion' surrounding the 'duty of care' obligations of staff, such that some organisations and staff appear to confuse 'duty of care' obligations with the doctrine of necessity, which protects individuals from liability in situations of overwhelming urgency. This 'confusion' results in misguided and unlawful uses of 'duty of care' obligations as the legal justification for non-consensual coercive treatment against people with disability.

Importantly, our investigation of these four core workplace concerns in the research literature further identified how these workplace concerns contribute to a 'no win' scenario, whereby use of restrictive practices both harms and traumatises the person with disability and leads to moral and ethical challenges for the staff who use them.

Driver 3: Under-resourced and understaffed services and supports for people with disability

The research literature suggests that there is a relationship between the resourcing of the workplace, staff perceptions of safety, and staff attitudes towards and use of restrictive practices for the purposes of maintaining a 'safe' environment. Indeed, studies indicate that while the four workplace concerns outlined above may drive use of restrictive practices in an immediate context, these concerns are in turn driven by structural and economic issues within organisations and 'care' sectors. Put simply, staff perceptions about risks, safety and

duty of care, and subsequent decisions to use restrictive practices, appear to be tempered by the level of resourcing and staffing of services and supports for people with disability. As explained in Chapter 4, understaffing is a longstanding, major problem in many institutional settings in Australia's disability sector, and in Australian disability services more generally. More research is needed on the relationship between use of restrictive practices and understaffing and under-resourcing for cost-efficiency purposes.

Driver 4: Socio-cultural attitudes and norms towards people with disability

There are few, if any, studies that have directly explored ableism as a driver for restrictive practices. However, broader findings within the research literature about ableism and the experiences of people with disability indicate that ableism encircles use of restrictive practices in at least three ways. First, views about people with disability as 'other' and 'lesser' are often disguised in the service and support sector as benevolence; as a 'commitment to care', or well-intended 'protection' for people with disability. These seemingly well-intended commitments to care and/or to protection of people with disability play a role in the use of restrictive practices in service settings, as well as in judicial and tribunal members' decisions to authorise restrictive practices such as guardianship orders and Supervised Treatment Orders. Second, people with disability may be placed in segregated environments – where restrictive practices are used more than in any other settings – because of purportedly 'well intended' but still 'inherently ableist' beliefs. Lastly, there appears to be a connection between ableism and violence against people with disability in general.

Importantly, people with disability are diverse, and may experience intersecting injustices and oppressions. While there is a paucity of research concerning the intersections of oppression and restrictive practices, existing research into racialised populations and women with disability indicate that use of restrictive practices isshaped by intersecting injustices and oppressions. For instance, studies indicate that racialized and First Nations peoples with disability experience some of the most coercive aspects of services, stay in residential treatment units longer than other people, and experience a disproportionate use of excessive force, restraint and punishment in school contexts. Women and girls are predominately targeted for forced sterilisation and menstrual suppression which often hinges on the intersecting social norms of ability, gender and sexuality.

Core Enabler: Law

In addition to the above four drivers for restrictive practices, Chapter 4 identified the core enabler of law. Law enables use of restrictive practices by not holding those who use them to account, and by denying redress to those who are subjected to them. As explained in Chapter 4, use of restrictive practices does not routinely give rise to criminal charges and civil litigation. This is because, in most cases, restrictive practices are granted formal authorisation by law. Drawing on legislation, court judgments and tribunal decisions, our analysis showed how law enables use of restrictive practices through multiple legal pathways for authorisation. Notably, as our analysis also showed, the source of authorisation for restrictive practices can

and does vary based on context; this variation results in a complex and inconsistent system. This system holds significant consequences for people with disability subject to restrictive practices, including the absence of liability and redress for the harm caused by use of restrictive practices.

The above findings about the ecological system, drivers and enabler of restrictive practices is represented in Figure 12 below.

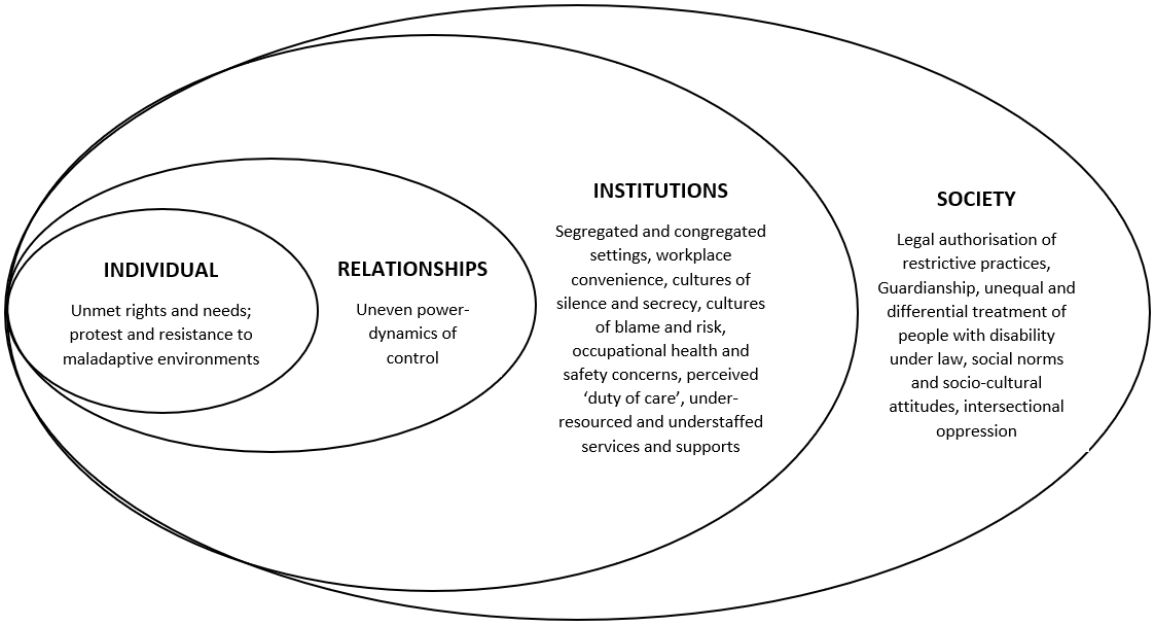


Figure 12: The ecological system of restrictive practices, including key drivers and enabler identified in research literature

RQ2: What measures and strategies are most effective in addressing these drivers and reducing or eliminating the use of restrictive practices against people with disability? Does this differ by setting, or by the type of restrictive practice? What measures have been proven ineffective in addressing restrictive practices?

Research question 2 was addressed across Chapters 5 and 6. In Chapter 5, section 1, we focused on the 'high-level' frameworks and principles used to guide current national approaches to reducing and/or eliminating restrictive practices in different systems and service settings. Importantly, as that Section of the chapter clarifies, while the past decade has seen several national and jurisdictional frameworks or principles for reducing and/or eliminating restrictive practices proposed and/or implemented in Australia across a range of different settings, including mental health settings, disability services settings and educational settings, it is unclear from current policy and research literature to what extent these frameworks and principles have been developed with consideration of the full range of drivers and enablers of restrictive practices identified in this report. There are also other gaps in knowledge. There has been little to no research conducted to date on the effectiveness

of current national approaches to reducing and/or eliminating restrictive practices in specific settings, including if certain frameworks or principles have proven ineffective in addressing restrictive practices. Additionally, it is not possible from the limited material currently available to identify if there are differences in effectiveness between settings. Further research will be required to address these particular areas of interest for the Disability Royal Commission.

What we were able to provide based on the current limited literature available were three observations about common features among current national and jurisdictional approaches to reducing and/or eliminating restrictive practices in different systems and service settings. We were also able to consider what is known within the broader research literature on the effectiveness of such features in general. Our observations are as follows:

1. **A lack of targets and indicators of progress**

   There have been few specific targets or indicators set for reduction and/or elimination of restrictive practices in different settings. There have also been few formal evaluations of progress against goals. Arguably, the lack of specific targets or indicators set for achieving reduction and/or elimination of restrictive practices contributes to the lack of knowledge currently held about the effectiveness of different measures and strategies.

2. **An emphasis on positive behaviour support**

   Several of the frameworks or principles for reducing and/or eliminating restrictive practices emphasise a need to build a workforce skilled in positive behaviour support planning and implementation. The effects of building a skilled, positive behaviour support workforce in disability service settings and educational settings in Australia have not been investigated at this time, however, as our response to RQ3 below details, the evidence-base for positive behaviour support has distinct limitations and produces mixed or inconclusive results.

3. **An emphasis on workforce development, training and education**

   Several of the high-level frameworks and principles used to guide current Australian approaches to reducing and/or eliminating restrictive practices in different systems and service settings refer to the necessity for workforce development, training and education. As indicated above, in the context of disability service settings and education settings, this emphasis on workforce development primarily revolves around positive behaviour support training and education. In mental health settings, many of the frameworks and principles emphasise staff training in recovery and trauma-informed practices. In health and other settings, there appears to be an emphasis on training members of the workforce to implement restraint safely. There are some positive findings in the broader research literature concerning training in trauma-informed practices and the reduction of restrictive practices. As outlined in Chapter 4, however, there are also findings to suggest that when staff training focuses on how and when to use restrictive practices – including any limitations to use of restrictive practices – this can produce counterintuitive and counterproductive effects, such as an increase in use of restrictive practices by staff.

While the above findings offer some indication of Australian measures and strategies that have been used to reduce use of restrictive practices against people with disability in a range of different settings, it is unclear if these measures and strategies will be able to address the *drivers* of restrictive practices identified in Chapter 4. Indeed, as indicated in the conclusion to Chapter 5, the legal authorisation and regulation of restrictive practices identified above as a key part of the ecological system of restrictive practices, and as playing a crucial enabling role in ongoing use of restrictive practices against people with disability, appears to remain unaddressed by current measures and strategies. This raises questions about the potential for all other dynamics of the ecological system of restrictive practices to change while this enveloping dynamic remains constant. To this end, Chapter 6 considered what other approaches may lead to the elimination of restrictive practices if this fundamental enabler for restrictive practices was addressed.

Chapter 6 outlined an eight-point action plan for eliminating restrictive practices. The action plan is responsive to the drivers and enabler identified in response to RQ1, and works to realise human rights of people with disability and redress and repair the harm to people with disability through restrictive practices, including restoring the dignity that has been stripped from people with disability, as explored in Chapter 1. The eight-point action plan for eliminating restrictive practices is summarised in Figure 13 below.

SOCIETY

1. **Prohibit Restrictive Practices**

End legal authorisation for use of restrictive practices

2. **Change Attitudes and Norms**

Support awareness raising to address discriminatory attitudes and norms

3. **Acknowledge and Address Historical Injustice**

Publicly acknowledge past wrongs, support truth telling

INSTITUTIONS

4. **Deinstitutionalise and Desegregate**

Deinstitutionalise and desegregate environments

RELATIONSHIPS

5. **Recognise the Autonomy and Leadership of People with Disability**

Support exercise of legal capacity

6. **Utilise Trauma Informed Support Approaches**

Reform service systems to recognise and respond to people with disability using trauma informed approaches

INDIVIDUAL

7. **Adequately Resource Independent Living and Inclusion**

Fully resource and realise Article 19 CRPD rights to independent living and inclusion

8. **Provide Redress for Victim-Survivors**

Seek to rectify injustice through law reform and a national redress scheme

Figure 13: Eight-point action plan to eliminate restrictive practices

We note that this proposed pathway has not been tested for effect, but each action is responsive to the drivers and enabler identified by this report, consistent with human rights obligations to people with disability, and consistent with contemporary approaches towards violence prevention more broadly. Indeed, as Chapter 6 details, many of the steps proposed have been taken in relation to other populations experiencing violence, abuse, neglect and exploitation. In light of the importance of the right to non-discrimination and equality for people with disability, we should not set a lower standard of what is possible in relation to preventing and responding to violence against people with disability. We should expect that what we can deliver for other populations we can also deliver for people with disability.

RQ3: Is positive behaviour support effective in reducing and eliminating the use of restrictive practices? Is it more effective in relation to certain types of disabilities, certain restrictive practices, or certain settings?

Chapter 5, section 3 provided a detailed review of the scholarly national and international literature on positive behaviour support. That review identifies five core findings of relevance to the Disability Royal Commission's research interests in the effectiveness of positive behaviour support (PBS). Those findings are:

1. **An evidence-base with distinct limitations**

   The research literature that comprises the evidence-base for PBS is characterised by two core limitations. First, many studies of the effectiveness of PBS are based on very small sample sizes. Second, much of the PBS evidence-base raises questions about the strength, accuracy and integrity of the findings. These limitations have led some researchers to classify this evidence-base as 'emerging' and not established.

2. **A focus on staff training as a mechanism for improving the quality of life of people with disability**

   The evidence-base for PBS is characterised by a focus on staff training in PBS, which appears to be underpinned by an assumption that there is a connection between staff training and positive outcomes for people with disability, in particular, improved quality of life.

This assumed connection is both infrequently studied, and on the rare occasion it has been studied, does not lead to improved quality of life for people with disability.

3. **A focus on the quality of plans, which prove to be poor quality**

There appears to be a belief that better staff training and knowledge of PBS will lead to better behaviour support plans being developed for people with disability. These better plans are then assumed, again, to lead to positive outcomes for people with disability. Studies of behaviour support plan quality typically find behaviour support plans to be of 'poor' or 'remarkably low' quality.

4. **Mixed and inconclusive results about the effectiveness of PBS**

There are mixed or inconclusive findings about the effectiveness of PBS. Some studies note positive outcomes. Here it is worth noting that some of these studies are subject to the limitations described in point 1 above, or only produce positive outcomes in relation to some elements, but not others. Other studies draw inconclusive findings or findings of no effect.

5. **The relationship between the environment and the person**

In studies that provided details about the nature of the 'intervention' that took place to produce a positive outcome, what appears to have changed is the quality of the environment and service being provided to the person with disability. In particular, positive outcomes appear to occur for people with disability when: (a) staff are nonconfrontational and consistent in their communication with the person with disability; (b) staff do not impinge on the autonomy of the person with disability; (c) people with disability are enabled to participate in meaningful activities of their choosing; and (d) the wishes of the person with disability are listened to and acted upon. Such findings are consistent with the understanding (explained in Chapter Three), that perceived 'behaviours of concern' are distress, protest and resistance made in a context of maladaptive environments of concern. These findings also raise important questions about the standards and quality of contemporary disability services and supports, and whether what is required is greater accountability of services rather than behavioural interventions in individuals receiving those services.

Notably, while our review of the scholarly national and international literature on positive behaviour support considered the use of positive behaviour support in a range of settings, and specified in relation to which settings each research finding was made, it is not possible from the research literature currently available to generalise if positive behaviour support is more or less effective in certain settings. Nor is it possible from current research to determine if positive behaviour support is more or less effective when used in relation to certain types of disabilities, or used in the context of certain restrictive practices. Further research will be required to address these particular areas of interest for the Disability Royal Commission.

RQ4: Are there local and international models of policies and practices that have resulted in effective reduction in the use of restrictive practices?

Chapter 5 provided detailed case studies of three key international approaches to reducing restrictive practices that have been studied, and which have had some success in reducing restrictive practices. These three examples have been adopted by several countries over the years, including, in two of the cases, Australia. Importantly, all three of the approaches identified as having had some success were developed for, and implemented within, the context of mental health settings. We were unable to identify any national or international examples of approaches to reduction and/or elimination that were developed for disability service settings and which have been evaluated for effectiveness. As noted below, however, some of the case examples from mental health contexts have been adopted in other settings. This transplantation to other settings has produced varying success.

The three examples of international models that have resulted in some success in reducing the use of restrictive practices are:

1. **The 'No Force First Project'**

   The No Force First project works from the proposition that effective recovery for people receiving services requires enabling people's 'choice, self-determination, and personhood.'[1013] Within this context, any form of force or coercion is understood to ultimately undermine the person's recovery. Studies of the No Force First approach in practice have shown reductions in seclusion and physical and chemical restraint in both general mental health wards, mental health crisis services, and forensic mental health wards. The No Force First approach has also been used in the context of forensic learning disability wards with some success, although notably, an evaluation in this context found that there was a significantly higher prevalence of physical restraint and harm in forensic learning disability wards as compared to forensic mental health wards, with this difference remaining post-introduction of the No Force First approach.[1014]

2. **Six Core Strategies to Reduce Seclusion and Restraint Use**

   The Six Core Strategies propose a trauma-informed approach to services, and can be summarised as: (1) leadership towards organisational change; (2) use of date to inform practice; (3) workforce development; (4) use of seclusion and restraint prevention tools; (5) consumer roles in inpatient settings; and, (6) debriefing techniques. Studies of the Six Core Strategies approach have shown reductions in restraint and seclusion in specialised mental health organisation, general mental health wards, and adolescent psychiatric hospitals. The Six Core Strategies has recently been adapted as part of the 2019 Australian College of Mental Health Nurses, *Safe in Care*, *Safe at Work Toolkit* for use in Australian mental health contexts. The impact *Toolkit* has not been formally evaluated at this time.

3. The ‘Safewards’ Model

Safewards is a clinical model for the management of conflict in mental health settings. The Model was originally developed in England as a tool to create a safer environment for both staff and patients. While the Safewards Model includes consideration of restrictive practices use, the model has a broader focus on understanding conflict, its causes, and staff responses to it. The Safewards Model has shown some positive effects in the context of general mental health settings, however it is unclear at this time if the effectiveness of the Safewards Model extends beyond general mental health settings. Evaluations of the model in other settings has provided mixed results. The Safewards Model has already been adapted and implemented in a range of different jurisdictions around the world, including in the Australian states of Queensland, New South Wales and Victoria, with evaluations of the Model in these jurisdictions providing mixed results.

There are two common features to the above three examples of international models for reducing restrictive practices that have had some success. First, there is an emphasis on leadership towards organisational change. This emphasis is supported by findings in the broader literature on restrictive practices. Second, there is an emphasis on fostering better relationship dynamics in service settings; that is, between staff and people with disability. This emphasis is supported by findings presented in Chapters 2 and 3 of this report about the experiences of people with disability who have been subject to restrictive practices.

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