



Queensland Advocacy Incorporated

Our mission is to promote, protect and defend, through advocacy, the fundamental needs and rights and lives of the most vulnerable people with disability in Queensland.

Systems and Individual Advocacy for vulnerable People with Disability

Restrictive Practices

**Submission by
Queensland Advocacy Incorporated**

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

December 2020

About Queensland Advocacy Incorporated

Queensland Advocacy Incorporated (**QAI**) is an independent, community-based systems and individual advocacy organisation and a community legal service for people with disability. Our mission is to promote, protect and defend, through systems and individual advocacy, the fundamental needs and rights and lives of the most vulnerable people with disability in Queensland. QAI's board is comprised of a majority of persons with disability, whose wisdom and lived experience of disability is our foundation and guide.

QAI has an exemplary track record of effective systems advocacy, with thirty years' experience advocating for systems change, through campaigns directed to attitudinal, law and policy reform and by supporting the development of a range of advocacy initiatives in this state. We have provided, for over a decade, highly in-demand individual advocacy through our individual advocacy services – the Human Rights Legal Service, the Mental Health Legal Service and the Justice Support Program and, more recently, the National Disability Insurance Scheme Appeals Support Program, Decision Support Pilot Program, Disability Royal Commission Advocacy Program and Education Advocacy Service. Our individual advocacy experience informs our understanding, and prioritisation, of systemic advocacy issues.

QAI's recommendations

QAI recommends:

1. The use of Restrictive Practices is an issue of vital importance that engages the human rights of a highly disempowered group in our society. It must be managed with sensitivity and an educated appreciation of the interrelated factors involved.
2. QAI notes the variation in definitions of 'Restrictive Practices' used by state and territory jurisdictions as well as between the different settings in which Restrictive Practices occur. An effective conversation about reducing or eliminating Restrictive Practices can only occur when there is semantic consensus and a nationally consistent approach to defining Restrictive Practices at the legislative, policy and operational levels.
3. Due to inadequate oversight and inconsistent reporting, the true prevalence of Restrictive Practices against people with disability is unknown. The lack of comprehensive data on the prevalence of Restrictive Practices is a significant concern that must be addressed with priority.
4. A person-centred approach must be taken when considering the use of Restrictive Practices. The person behind the behaviour must be understood. This includes identifying potential catalysts for behaviours of concern by considering historical and current life experiences as well as environmental, relationship, sensory, mental health and physical factors that might be contributing to a person's experience. It includes learning about communication difficulties and the types of situations in which a person feels unsafe, threatened or disempowered. In many circumstances, behaviour is interpreted out of context and is incorrectly labelled as unprovoked aggression, justifying the use of a Restrictive Practice when in fact the use of a Restrictive Practice will result in an escalation rather than reduction of the behaviour of concern.
5. The perceived 'behaviour of concern' must be seen within its wider context. That is, a community that has historically devalued people with disability, where unconscious bias is

entrenched in the minds of those supporting people with disability and where motives of personal gain through risk adversity are present. Only when the analysis is broadened to include the systemic structures at play, will effective measures to reduce or eliminate the use of Restrictive Practices be developed.

6. There is significant research establishing the negative consequences of Restrictive Practices and a lack of evidence to support their effective use in addressing and reducing behaviours of concern. Measures that avoid or eliminate the use of Restrictive Practices must be prioritised, including Positive Behaviour Support which involves an ongoing process of research-based assessments, interventions and data-based decision-making that is focussed on building social and other functional competencies, supportive contexts and preventing the occurrence of behaviours of concern.
7. Greater consultation with and involvement of people with disability at the policy level is required in order to ensure concepts born of ableism do not continue to dominate.
8. Elevation of a supported decision-making approach for all people with disability, in which a person is supported to exercise their autonomy and maintain their legal capacity through assisted decision-making. QAI believes that this will reduce the incidence of communicative behaviours that can lead to the use of Restrictive Practices. This extends to the rare occasions in which the use of a Restrictive Practice cannot be avoided. The person must be supported to be involved in decision-making regarding the use of a Restrictive Practice, as this will better facilitate the reduction and potential elimination of the Restrictive Practice in a more humane and timely manner. QAI foresees the need for ongoing community education regarding the concept of legal capacity, its fluctuating nature and the role that increased autonomy and control can play in increasing a person's capacity.
9. Safeguards must ensure decisions to impose Restrictive Practices are transparent, open to independent scrutiny and advocacy and are reviewable by an independent body. It is also critical that reporting and data collection obligations are accompanied by mandatory training of service providers and staff who fail to meet the goal of reducing or eliminating the use of Restrictive Practices, and ultimately the removal of those staff when continued failure to comply with targeted reduction occurs.
10. Address the piecemeal approach to regulation, monitoring and oversight by implementing a national mechanism to monitor the use of Restrictive Practices, including in places of detention where unregulated Restrictive Practices continue to be inflicted on people with disability.
11. In addition to procedural safeguard measures that govern the use of Restrictive Practices, such as the requirement to obtain a 'Behaviour Support Plan' for NDIS participants, greater focus needs to be placed on developing substantive safeguard measures that effectively address the power disparity and inadequate service provision that often underpins a perceived need to use a Restrictive Practice to address a behaviour of concern.
12. Educating service providers regarding prejudice and bias towards people with disability, as an essential starting point in addressing the overuse of Restrictive Practices on people with disability and in creating the attitudinal change required to ensure the human rights of all people with disability are respected and protected.

Introduction

QAI welcomes the Royal Commission's focus on the use of Restrictive Practices and is grateful for the opportunity to make a submission on the issue. QAI considers the use of Restrictive Practices to infringe the fundamental human rights of people with disability. Despite the emphasis placed on autonomy and individual choice in neo-liberal democracies such as Australia, the use of actions that limit the rights or freedom of movement of individuals with the aim of controlling behaviour raises uncomfortable questions regarding the extent to which these freedoms are enjoyed by everyone. Accordingly, QAI endorses the Commission's commitment to taking a human rights-based approach to examining the unethical use of Restrictive Practices against people with disability.

Restrictive Practices are used as a form of behaviour control, applied to individuals who are considered to exhibit 'challenging behaviours' or 'behaviours of concern'. There are numerous issues with this approach, not least the assumption that the problem lies with the individual rather than the systems that control human behaviour and that the solution lies with a restriction of personal freedoms rather than structural change. Systemic change that addresses the use of Restrictive Practices on people with disability is urgently needed. Efforts to understand the person behind the behaviour must become routine practice. Stronger legislative measures that ensure transparency and accountability must be consistently applied to all settings where Restrictive Practices occur. Removing prejudicial attitudes towards people with disability by implementing measures such as supported decision-making is a vital part of achieving this goal. In balancing the tension between individual autonomy and personal safety, people with disability must be afforded the life experiences required to contextualise potentially harmful decisions. This will only occur when models of segregation are disbanded and we achieve a truly inclusive society. A rights-based response that operationalises the concept of autonomy is therefore required.

What are Restrictive Practices?

Restrictive Practices encompass a wide range of actions that have the result of limiting a person's human rights. QAI notes the variation in definitions of 'Restrictive Practices' used by state and territory jurisdictions as well as between the different settings in which Restrictive Practices occur. QAI is of the position that an effective conversation about reducing or eliminating Restrictive Practices can only occur when there is semantic consensus and a nationally consistent approach to defining Restrictive Practices at the legislative, policy and operational levels.

With this caveat in mind, QAI endorses the definition provided in the Issues Paper which defines a Restrictive Practice as "...any action, approach or intervention that has the effect of limiting the rights or freedom of movement of a person."¹ Restrictive Practices are "...interventions that restrict an individual's movement, liberty and/or freedom to act independently in order to take immediate control of a dangerous situation, end or reduce significantly the danger to the person or others, and contain or limit the person's freedom for no longer than is necessary."² Restrictive

¹ Commonwealth, State and Territory Disability Ministers, National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector, (1 May 2013).

² Department of Health, A positive and proactive workforce: A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health (2014) <https://www.skillsforcare.org.uk/Documents/Topics/Restrictive-practices/A-positive-and-proactive-workforce.pdf> 15; see also Amaze, Position Statement – Restrictive Practices (March 2018) <https://www.amaze.org.au/wp-content/uploads/2019/06/Amaze-Restrictive-Practices-March-2018.pdf> 2; Australian Law Reform Commission,

Practices are imposed as a response to a perceived 'behaviour of concern' and occur in all domains of life, including education, health and justice settings. QAI notes the discussion regarding seclusion and restraints (physical, chemical, mechanical, environmental and psychosocial) and provides the following examples of Restrictive Practices as applied to people with disability by way of further explanation³:

- **Containment** – the practice of physically preventing a person from freely exiting the premises, other than by seclusion. For example, by locking a gate. Concerningly, this does *not* include situations where a person is contained due to a perceived 'skills deficit' as the use of 'Locked gates, doors or windows' has been removed from Restrictive Practices legislation. QAI is concerned that this exemption can be misused by service providers who fail to explore the individual's abilities, build their capacity or seek to find an alternative, less restrictive measure. Containment in this situation is therefore arguably a Restrictive Practice as a result of poor-quality service provision rather than a preventative safety mechanism.
- **Seclusion** – the practice of physically confining a person alone in an area or room from which they cannot exit freely. That is, the door is unlockable from the outside only. QAI is particularly concerned about the lack of supervision that occurs over people in seclusion, elevating levels of anxiety and depression and increasing risks of self-harm. Conversely, if a person chooses to lock themselves into a room, for example to remove themselves from a challenging situation or to seek privacy, this can be construed as an instance of seclusion by a service provider recording instances of Restrictive Practices to profile a person in order to justify funding decisions.
- **Chemical restraint** – the practice of using medication for the primary purpose of controlling behaviour that may cause harm to a person or others. For example, using diazepam to sedate an adult when the medication is not otherwise clinically indicated. QAI is concerned about misuse of medication when a person has not been involved in discussions or decision-making regarding their healthcare or educated as to potential side-effects. For example, when adults with intellectual disability are prescribed antilipidinal medication without their knowledge or informed consent.
- **Mechanical restraint** – the practice of using a device for the primary purpose of restricting movement and controlling behaviour that causes harm to a person or others. For example, placing a person in a chair with shackles or using a splint that restricts a person's movement of their arms or legs. QAI is concerned about the extent to which these practices are used as a means of controlling 'undesirable' behaviour in the absence of any effort to try and understand the behaviour and what the person is trying to communicate.
- **Physical restraint** – the practice of using any part of another person's body to restrict the movement of a person for the primary purpose of controlling their behaviour in order to prevent harm to the person or others. For example, holding a person's arm to prevent them from striking someone. QAI is concerned about the physical and psychological harm that arises from the use of these practices, and that they often result in an escalation, rather than de-escalation, of the behaviours of concern.
- **Restricting access** – the practice of restricting a person's access to an object for the primary purpose of preventing the person from using the object to cause harm to

Restrictive Practices in Australia (May 2014) <https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-dp-81/8-restrictive-practices/restrictive-practices-in-australia/> 8.4.

³ Queensland Advocacy Incorporated, Conclusions on the Use of Restrictive Practices for People with an Intellectual or Cognitive Impairment (October 2014) <https://gai.org.au/wp-content/uploads/2017/10/Final-QAI-conclusions-on-the-use-of-RP-October-2014-final-version-2.pdf> 8.

themselves or others. For example, restricting access to knives. QAI is concerned about the extent to which people with disability living in group homes are restricted access to their own rooms or possessions as punitive measures rather than safety mechanisms.

Further to the above, the following acts are also considered to be Restrictive Practices:

- Constant and intensive supervision or not ensuring an accessible environment;⁴
- Forcing a person to wear clothing specifically designed to impede behaviours of concern;⁵
- Employing psychosocial techniques which can impact a person's exercise of choice and self-determination;⁶
- Using emotional restraints which make a person feel like they must comply with behavioural expectations;⁷
- Environmental restraint;⁸
- Clinical holding;⁹ or
- Explicit restrictions on where a person lives, who they live with, how they spend their time, access to personal monies, their right to access to the local community, their right to sexual expression, their right to privacy.¹⁰

How often are Restrictive Practices used?

Due to inadequate oversight and inconsistent reporting, the true prevalence of Restrictive Practices against people with disability is unknown. According to the Mental Health Watchdog, the use of Restrictive Practices "...is rife, yet remains hidden from public scrutiny due to a lack of mandatory reporting required by law in every state of Australia, and a lack of appropriate action taken when reports are released. Public restraint reporting has not been uniformly regulated, with states and territories having different policy and legislative requirements regarding restraint."¹¹ Similarly, The Australian Institute on Health and Welfare has called reporting a 'novel exercise' and has raised concern regarding the reporting of the use of chemical restraints in mental health facilities, which it says is 'rampant'.¹²

This concern has been echoed by the Royal Commission into Aged Care Quality and Safety which found:

There is currently no comprehensive national data on the use of restrictive practices in residential aged care facilities in Australia. Residential aged care service providers have not been required to record and report on the use of restraint or restrictive practices on residents, although the Australian Government's National Aged Care Quality Indicator

⁴ Active Social Care Limited, *Restrictive Practices* (ND) <https://activesocialcare.com/handbook/safeguarding-adults/restrictive-practices>.

⁵ Adelaide Night and Day Family Therapy, *Tied Up in Knots: Systemics, Occupational Therapy and Restrictive Practices* (April 2011) <https://adelaidetherapy.com/tied-up-in-knots-systemics-occupational-therapy-and-restrictive-practices/>.

⁶ Australian Psychological Society, *Evidence-based guidelines to reduce the need for restrictive practices in the disability sector* (2011) <https://www.psychology.org.au/getmedia/c986ad95-d312-4b2c-89da-3157b215f118/Restrictive-Practices-Guidelines-for-Psychologists.pdf> 8.

⁷ Brophy, Roper, Hamilton et al, *Consumers and Carer perspectives on poor practice and the use of seclusion and restraint in mental health settings: results from Australian focus groups* (February 2016) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4744440/>.

⁸ Community Living Australia, *Restrictive Practices Information Booklet* (2018) https://www.claust.com.au/uploads/resource_downloads/18/Restrictive%20Practices%20Toolkit.pdf 6.

⁹ Department of Education, *Restrictive practices fact sheet: Clinical holding* (ND) <http://ppr.det.qld.gov.au/education/learning/Procedure%20Attachments/Restrictive-practices/fact-sheet-clinical-holding.pdf>.

¹⁰ KARE Policy, *Restraint/Restrictive Practices Policy* (May 2018) <http://www.fedvol.ie/fileupload/Quality%20&%20Standards/Additional%20Policies%202018/KARE/Restraint%20Restrictive%20Practices%20Policy.pdf> 3.

¹¹ Citizens Committee on Human Rights: The Mental Health Watchdog, *Restraint Is Criminal* (2020) <https://cchr.org.au/restraint-is-criminal>

¹² Ibid

Program will introduce reporting requirements relating to physical restraint from 1 July 2019.¹³

It is difficult to compensate for the lack of evidence by making estimates because definitions of the different types of restraint have been used interchangeably throughout the literature.¹⁴ Dr Spivakovsky has further testified that the Australian Bureau of Statistics' tendency to use quantitative methods of data collection has prevented patients from providing first-hand accounts of their experiences of being subjected to Restrictive Practices.¹⁵ The lack of comprehensive data on the prevalence of Restrictive Practices is a significant concern that must be addressed with priority.

Notwithstanding the limitations of the data available, we know that Restrictive Practices are being used on people with disability at an alarming rate. Indeed, the United Nations Committee on the Rights of Persons with Disabilities has raised concern about the current use of Restrictive Practices within Australia, especially for individuals with intellectual impairment or psychosocial disability.¹⁶

In order to highlight the issue of people with disability being subjected to Restrictive Practices, QAI has constructed the following chronology of evidence:¹⁷

Date	Quote
2005-2006	"In Victoria, the Intellectual Disability Review Panel reported that...28% of residents in accommodation services and 23% of residents in respite services were exposed to restraint and/or seclusion...Furthermore, the incidence of restraint in Australia (23-28%) is considered high compared with the United Kingdom, where between 7-17% of adults with a disability are subjected to restraint." ¹⁸
April 2011	"At least a quarter of all people with an intellectual disability, including young people and children, are believed to have been subject to restraint in care, including physical, chemical, mechanical restraint and seclusion." ¹⁹
August 2014	"Participants were asked if they had ever personally experienced seclusion or restraint in relation to a mental health issue. 369 participants (31%) indicated that they had personally experienced seclusion or restraint in relation to a mental health issue; with 817 participants (69%) indicating that they had not personally experienced seclusion or restraint in relation to a mental health issue. 54 participants did not answer the question." ²⁰

¹³ Royal Commission into Aged Care Quality and Safety, *Restrictive Practices in Residential Aged Care in Australia* (May 2019) <https://apo.org.au/sites/default/files/resource-files/2019-05/apo-nid233756.pdf> 15.

¹⁴ NSW Communities and Justice, *Restrictive Practice Authorisation: Information For Families* (ND) https://www.facs.nsw.gov.au/_data/assets/pdf_file/0006/775365/Restrictive-Practices-Information-for-families.pdf 1.

¹⁵ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Transcript* (December 2019) <https://disability.royalcommission.gov.au/publications/transcript-3-december-2019> 24.

¹⁶ Amaze, *Position Statement – Restrictive Practices* (March 2018) <https://www.amaze.org.au/wp-content/uploads/2019/06/Amaze-Restrictive-Practices-March-2018.pdf> 3.

¹⁷ See Australian Institute of Health and Welfare, *Mental health services in Australia* (January 2020) <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/restrictive-practices> - "this section reports national data on the use of seclusion (when a person is confined alone in a room or area where free exit is prevented) and restraint (when a person's freedom of movement is restricted by physical or mechanical means) in specialised mental health public hospital acute service units".

¹⁸ Australian Psychological Society, *Evidence-based guidelines to reduce the need for restrictive practices in the disability sector* (2011) <https://www.psychology.org.au/getmedia/c986ad95-d312-4b2c-89da-3157b215f118/Restrictive-Practices-Guidelines-for-Psychologists.pdf> 9.

¹⁹ Adelaide Night and Day Family Therapy, *Tied Up in Knots: Systemics, Occupational Therapy and Restrictive Practices* (April 2011) <https://adelaidtherapy.com/tied-up-in-knots-systemics-occupational-therapy-and-restrictive-practices/>.

²⁰ Melbourne Social Equity Institute, *Seclusion and Restraint Project Report* (August 2014) https://socialequity.unimelb.edu.au/_data/assets/pdf_file/0017/2004722/Seclusion-and-Restraint-report.PDF 67.

July 2017	“Over a number of years, Advocacy for Inclusion encountered numerous and regular instances of people with disabilities being chemically restrained as a form of restrictive practices in institutional settings.” ²¹
December 2017	“A 12-month study in Victoria, Australia examined the use of three forms of restraint (chemical, mechanical and seclusion) in people with an intellectual disability and/or acquired brain injury. It found that approximately 9% of those studied had been subjected to one or more of these forms of restraint. The instance of chemical restraint far outweighed the other two forms of restraint, accounting for 83% of all reported incidents. Chemical restraint was found to be administered on a routine basis.” ²²
2018	In Western Australia three organisations supporting sixty individuals agreed to be “champions” for change in the use of restrictive practices and were asked how many restrictive practices were used – their answer was fewer than ten. However, after training on restrictive practices, they identified over a hundred restrictive practices – meaning their use was far more prevalent and widespread than was expected. ²³
February 2019	“In 2017, figures from 40 mental healthcare trusts were released showing that there were 59,808 reported incidences in which care recipients had been subjected to a restrictive practice.” ²⁴
July 2019	“Data from the Victorian Government’s 2017-18 Mental Health Services Annual Report showed no diminution in the use of seclusion, restraint, and compulsory treatment in the mental health system in the past three years. Furthermore, Community Visitors point to Victorian Health Services performance data showing that seclusion events in child and adolescent units have doubled.” ²⁵
August 2019	“A survey of 771 students with disability conducted by Children and Young People with Disability Australia (CYDA 2017) identified that 19% of all respondents had experienced restraint at school, and 21% of respondents had experienced seclusion. CYDA is only part way through completing their 2019 national education survey in August and September 2019, and already the results for NSW (n=75) show 15% of children with disability experienced restraint and 21% experienced seclusion in the last year.” ²⁶
October 2019	“Over the 6-month study period, 159 young people were admitted and this accounted for 188 admissions. Over half (54.3%) of admissions were involuntary and restrictive intervention were used in 17.6% of admissions. Specifically, 15.7% (N = 25) of young

²¹ Advocacy for Inclusion, *Response to Australian Human Rights Commission: OPCAT in Australia Consultation Paper* (July 2017) https://humanrights.gov.au/sites/default/files/06.%20Advocacy%20for%20Inclusion%20OPCAT%20sub%2019%20July%202017.pdf?_ga=2.156145855.587831650.1592184148-998228770.1549418566 6.

²² Health Information and Quality Authority, *Literature Review – Restrictive Practices* (December 2017) https://www.higa.ie/sites/default/files/2020-03/Restrictive-Practices_Literature-Review.pdf 7.

²³ Community Living Australia, *Restrictive Practices Information Booklet* (2018) https://www.claust.com.au/uploads/resource_downloads/18/Restrictive%20Practices%20Toolkit.pdf 5.

²⁴ Daniel Rippon, *The Impact of Restrictive Practices on the Well-being of Care Staff* (February 2019) <https://www.studio3.org/post/the-impact-of-restrictive-practices-on-the-well-being-of-care-staff>.

²⁵ Pearce and Chesterman, *Submission to the Royal Commission into Victoria’s Mental Health System* (July 2019) <https://www.publicadvocate.vic.gov.au/resources/submissions/mental-health-1/626-opa-submission-to-royal-commission-into-victorias-mental-health-system-05-july-2019/file> 21.

²⁶ Empowered Community Services, *The Use of Restrictive Practices Policy and Procedure* (December 2019) https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKewjs-4GTiFTpAhVlzDgGHZSIAjgQFjIAeqQIAxAB&url=https%3A%2F%2Fempoweredcommunityservices.com%2F%3Fiet_download%3D1247&usq=AOvVaw0sM68tqr7dPbbZH18ZU9U 9.

<p>people experienced restraint, 10.1% (N = 16) were secluded, and 8.1% (N = 12) experienced medication without consent. Absent insight and involuntary status on admission were associated with restrictive interventions.”²⁷</p>

Where and in what circumstances are Restrictive Practices used?

Restrictive Practices occur in all corners of society. They occur in any setting in which a person with a disability is perceived to exhibit a ‘behaviour of concern’ that purportedly poses a threat to the safety of the person or others. This includes environments such as at home,²⁸ in supported accommodation, group homes,²⁹ residential aged care facilities, mental health facilities,³⁰ prisons³¹ and schools.³² The use of Restrictive Practices has been found to differ depending upon the individual characteristics of the person with disability. For example, older adults with psychosocial disability are at a higher risk of being subjected to Restrictive Practices. The Citizens Committee on Human Rights found that mentally ill elderly South Australians had been physically restrained or held in isolation more than patients of any other age group.³³ Indeed the 2014/15 Chief Psychiatrist Annual Report showed older mental health patients accounted for 79% (3,565) of restraint and seclusion occurrences.³⁴ This is corroborated by Grant Everett who stated that the people most likely to experience restraint or seclusion in Australia are those who are simultaneously suffering from mental health, intellectual or behavioural issues and are elderly.³⁵

People with communication difficulties are especially vulnerable to Restrictive Practices, often imposed in response to a person’s attempts to communicate in the only way that they can. Research has shown that even a person who uses verbal communication may rely upon the manifestation of unique behaviours as their reflex communication strategy when under duress, anger, fear or emotional upheaval. In the context of people with a disability, this behaviour can be aggravated by their disempowerment, isolation and decreased ability to communicate their experience which in turn, is then exacerbated by the use of Restrictive Practices.³⁶

The use of Restrictive Practices on children with disability in educational settings is of particular concern to QAI. Through our Education Advocacy Service, QAI has provided individual advocacy for children within the state education system who have been subjected to Restrictive Practices. Within Australia, the use of Restrictive Practices on children with disability in educational settings has been documented to include children with disabilities being locked in

²⁷ Goz, Rudhran, Blackburn et al, *Prevalence and Predictors of Restrictive Interventions in a Youth-Specific Mental Health Inpatient Unit* (October 2019) <https://pubmed.ncbi.nlm.nih.gov/30328276/>.

²⁸ Adelaide Night and Day Family Therapy, *Tied Up in Knots: Systemics, Occupational Therapy and Restrictive Practices* (April 2011) <https://adelaidetherapy.com/tied-up-in-knots-systemics-occupational-therapy-and-restrictive-practices/>.

²⁹ Amaze, *Position Statement – Restrictive Practices* (March 2018) <https://www.amaze.org.au/wp-content/uploads/2019/06/Amaze-Restrictive-Practices-March-2018.pdf> 3.

³⁰ Office of the Senior Practitioner, *Positive solutions in practice: Finding alternatives to restrictive interventions* (October 2012) <https://providers.dhhs.vic.gov.au/sites/default/files/2017-08/Positive-solutions-in-practice-finding-alternatives-to-restrictive-interventions.pdf> 3.

³¹ Parliament of Australia, *Chapter 4 – Disability-specific interventions* (2015) https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Violence_abuse_neglect/Report/c04 para 4.95-4.99.

³² Australian Law Reform Commission, *Restrictive Practices in Australia* (May 2014) <https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-dp-81/8-restrictive-practices/restrictive-practices-in-australia/> para 8.4.

³³ Citizens Committee on Human Rights: The Mental Health Watchdog, *Restraint Is Criminal* (2020) <https://cchr.org.au/restraint-is-criminal>.

³⁴ The Annual Report of the Chief Psychiatrist of South Australia (2014-2015) <https://www.sahealth.sa.gov.au/wps/wcm/connect/ce94ce80404d6223a59be7deb8488407/Chief+Psychiatrist+Annual+Report+2014-15.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-ce94ce80404d6223a59be7deb8488407-m7SmJwA>

³⁵ Grant Everett, *Dr Jeffrey Chan asks: Can we end restraint and seclusion in Australia?* (April 2019) <https://panoramaonline.com/2019/04/28/dr-jeffrey-chan-asks-can-we-end-restraint-and-seclusion-in-australia/>.

³⁶ Queensland Advocacy Incorporated, *Conclusions on the Use of Restrictive Practices for People with an Intellectual or Cognitive Impairment* (October 2014) <https://qai.org.au/wp-content/uploads/2017/10/Final-QAI-conclusions-on-the-use-of-RP-October-2014-final-version-2.pdf> 13.

cupboards, separated from their peers or physically manhandled by way of purportedly addressing their developmental or disability needs. This is concerning, both for the potential physical and psychological harm caused to the individual child and their family and also because these Restrictive Practices fall outside the scope of practices regulated by the relevant legislation in each jurisdiction. Requirements to seek approval to implement behaviour support plans simply do not exist. Instead, the application of Restrictive Practices in educational settings occurs at the unfettered discretion of school Principals, without regulation or independent oversight. By the time the Regional office becomes involved, the student has typically suffered significant harm and been denied access to important learning opportunities. Additionally, the use of Restrictive Practices has the effect of perpetuating discriminatory attitudes, where children with disability are 'othered', problematized and essentially primed for a lifetime of segregation and inequality.

Why are Restrictive Practices used?

Despite assertions that Restrictive Practices are a necessary response to manage a crisis or avert imminent danger, it is QAI's experience that Restrictive Practices are often the result of a myriad of factors, many of which do not stem from the individual concerned. Restrictive Practices can occur as a result of prejudicial and discriminatory attitudes and negative stereotyping. Many people with disability experience a lifetime of devaluation from birth, through their school years and beyond. The imprint left upon people by the multiple layers of discrimination, exclusion and rejection is often a terrible burden of loneliness, pain or anger. When any, and at times the only, interaction they have with another person is in the form of a direction or instruction, a 'do this, don't do that' chorus echoed throughout the years, it is not unexpected, having regard to normal human behaviour, that some people will retreat into themselves while others will attempt to exert some will and determination. The person, their behaviour and the message they are trying to communicate is misunderstood and lost in the situation. Instead, they acquire a reputation that is difficult to shed and are labelled as 'challenging' or worse. Those in positions of power seek to exert their dominance over the individual by restricting their liberties, ironically often leading to self-fulfilling prophecies. That is; the suppression of the individual's rights has the effect of exacerbating their disempowerment, inflaming the perceived behaviour of concern and thereby legitimising the ongoing use of the Restrictive Practice. Concerningly, this can occur in the absence of any, or any adequate, assessment of the efficacy of the use of the Restrictive Practices.³⁷

Other reasons which have been identified as justifications for Restrictive Practices include:

- Belief that the practice is 'good for them';
- Belief that the person needs to be disciplined;
- Belief that it will help the person achieve their goals;
- Habit, when a practice has always been part of a service;³⁸
- A lack of knowledge about the person, their disability and their life experience;
- A failure to understand the meaning of the behaviour and what the person might be trying to communicate through the behaviour of concern;

³⁷ Queensland Advocacy Incorporated, *Conclusions on the Use of Restrictive Practices for People with an Intellectual or Cognitive Impairment* (October 2014) <https://gai.org.au/wp-content/uploads/2017/10/Final-QAI-conclusions-on-the-use-of-RP-October-2014-final-version-2.pdf> 42.

³⁸ *Guidelines for Using Restrictive Practices* (ND) <http://www.humanservices.alberta.ca/documents/pdd/pdd-central-guidelines-using-restrictive-practices.pdf> 3.

- A lack of functional assessment of the behaviour, the context in which it occurs, the antecedents and the consequences;
- A lack of a support plan in which the person details their likes and dislikes, triggers for particular behaviours, what strategies to use and when and which practices work well to address the behaviour;
- A lack of planned safeguards due to a failure to anticipate the likelihood that there might be a situation in which a quick response is required in an emergency.³⁹

The aforementioned suggests that societal prejudice and poor-quality service provision are among the primary reasons for the use of Restrictive Practices. Research from several studies has indicated that the use of Restrictive Practices largely comes down to systemic issues of poor practice occurring within an institution, with many practitioners who use Restrictive Practices reporting feeling under pressure from organisational culture, the physical environment, under-resourced mental health services, fear and 'stigma'.⁴⁰ As Advocacy for Inclusion puts it, situations in which Restrictive Practices arise are the result of the habits or blanket rules practitioners have instituted in order to adapt:

There is continuous strong evidence that staffing shortages in disability support services are contributing to the use of chemical restraint as workers either do not have time to, or are not skilled in, communicating effectively with people with communications barriers. There is no specific evidence that chemical restraint is being used maliciously, or even knowingly, rather it appears that a culture has developed of using it as a convenient mechanism to work more quickly with people who are interpreted as being "difficult" or "challenging". It seems to have become the cultural norm to make things easier for disability workers and health professionals.⁴¹

Another factor contributing toward the use of Restrictive Practices is concern about risk to an organisation's reputation. As an interviewee implied to Dr Spivakovsky, the people who treat the patients who receive Restrictive Practices are terrified of one of their charges escaping and doing something terrible, given that such a scenario would reflect badly on the organisation and possibly impact the amount of funding it receives in the future.⁴² This notion is corroborated by Muir-Cochrane, O'Kane and Oster who cite a quote which exemplifies the fears of Australian mental health nurses in regard to what might happen if seclusion and restraint were to be removed as available options when dealing with mental health patients. The anonymous nurse attests that, should Restrictive Practices be completely eliminated, it would be no longer possible to practice in certain areas, as "no amount of de-escalation or therapeutic input is going to make the situation safe" and, should the worst-case scenario occur and someone is harmed by an elevated patient in her care, she will ultimately be blamed for her actions - or lack thereof.⁴³

³⁹ Peter Millier, *Positive Behaviour Framework: Restrictive Practice(s) Issue Paper* (October 2011)

<http://www.disability.wa.gov.au/Global/Publications/For%20disability%20service%20providers/Guidelines%20and%20policies/Behaviour%20Support/Restrictive%20Practices%20Issues%20Paper.pdf> 12.

⁴⁰ Brophy, Roper, Hamilton et al, *Consumers and Carer perspectives on poor practice and the use of seclusion and restraint in mental health settings: results from Australian focus groups* (February 2016) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4744440/>.

⁴¹ Advocacy for Inclusion, *Response to Australian Human Rights Commission: OPCAT in Australia Consultation Paper* (July 2017) https://humanrights.gov.au/sites/default/files/06.%20Advocacy%20for%20Inclusion%20OPCAT%20sub%2019%20July%202017.pdf?_ga=2.156145855.587831650.1592184148-998228770.1549418566 4-5.

⁴² Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Transcript* (December 2019) <https://disability.royalcommission.gov.au/publications/transcript-3-december-2019> 26.

⁴³ Muir-Cochrane, O'Kane and Oster, *Fear and blame in mental health nurses' accounts of restrictive practices: Implications for the elimination of seclusion and restraint* (March 2018) <https://onlinelibrary.wiley.com/doi/full/10.1111/inm.12451>.

Whether it is a belief that a person with a disability ‘needs’ to be restricted for ‘their own good’ or a belief that the person is being ‘difficult’ and therefore deserves to be punished or controlled or a fear about what will happen to an organisation’s reputation if an adverse event was to occur, it is clear that the use of Restrictive Practices involves much more than just the perceived ‘behaviour of concern’. Yet there is little acknowledgement of this by those that impose Restrictive Practices or by government entities seeking to monitor their use. The perceived ‘behaviour of concern’ must be seen within its wider context. That is, a community that has historically devalued people with disability, where unconscious bias is entrenched into the minds of those supporting people with disability and where motives of personal gain through risk adversity are rife. It must also be viewed as the social construct that it is. What someone considers to be a ‘challenging behaviour’ may differ from one person to the next, based upon their understanding of the individual concerned. For example, someone constantly seeking to leave their residence might be viewed as attempting to abscond, whereas another person might intuitively understand that the person is not engaged in any meaningful activities or is simply seeking fresh air or exercise. The interpretation of the behaviour therefore determines the response. In some situations, this will lead to the use of Restrictive Practices whilst in others, less restrictive alternatives will actively be pursued. Only when the analysis is broadened to include the systemic structures at play, will effective measures to reduce or eliminate the use of Restrictive Practices be developed.

What are the effects of Restrictive Practices?

QAI considers that the use of Restrictive Practices is a violation of human rights on the grounds that such treatment, if applied to people without disability, would not be tolerated but instead viewed as criminal conduct. People with disability should be treated with the same dignity and respect as all other humans. The application of Restrictive Practices on people with disability is therefore discriminatory, cruel, inhuman and degrading and must be ceased.

The use of Restrictive Practices to manage behaviour that is considered to be challenging results in adverse outcomes for both the individual and broader community. A Restrictive Practice can re-traumatize a vulnerable individual and increase their need for support over time, thereby increasing both the psychological and economic burden to the community. Serious physical adverse consequences can include serious injury, such as asphyxia and cardiac complications or even death.⁴⁴ Serious psychological adverse consequences can include reduced quality of life and well-being, increased depression and anxiety and increased risk of self-harm. This is unsurprising if we consider the likely response of any person, whether they have a disability or not, to the imposition of a Restrictive Practice which is tantamount to abduction, imprisonment, bondage, solitary confinement, chemical sedation or sterilisation. This is exacerbated in the case of persons with increased vulnerability and diminished legal autonomy.

The literature identifies the following adverse effects from using Restrictive Practices:⁴⁵

⁴⁴ The Australian Psychological Society Ltd, Evidence-Based Guidelines to Reduce the Need for Restrictive Practices in the Disability Sector, 2001.

⁴⁵ Kirsten Foss, *Restrictive Intervention Legislation in Tasmania* (July 2016) https://eprints.utas.edu.au/23003/1/Foss_whole_thesis.pdf 19, 35.

- **Occupational apartheid** - the experience of alienation and deprivation which occurs when children with disabilities become occupationally marginalised when their carers segregate them from their peers. They are precluded from partaking in everyday activities because their primary occupations of playing, being a student, having a hobby and developing life skills are constantly challenged, compromised, trivialised and dismissed by those who inflict unwanted and unnecessary restraint;⁴⁶
- **Diminished quality of life**, health and wellbeing, which can give rise to serious adverse consequences such as increased behaviours of concern, post-traumatic stress and serious injury;⁴⁷
- **Adverse effects on the therapeutic relationship** between a person with disability and their treating clinician;⁴⁸
- **Immediate escalation of distress**, intense feelings of despair, shame, terror, rage, anxiety, helplessness, humiliation, vulnerability, loneliness, injustice and powerlessness;⁴⁹
- **Trauma**, physical injury, sickness and subsequent increased costs for the health system;⁵⁰
- Anger and **distress for staff members** who have a traumatic background, which can lead to increased staff absenteeism for psychological anguish;⁵¹
- An **additive effect** where antipsychotic medications are used concurrently with physical restraints, resulting in a decline in cognitive performance, ADL performance and increased walking dependence in residents that had been physically restrained, muscular atrophy, demineralisation of bones, shortening of tendons, arrested motor development and disuse of limbs, agitation, functional decline, gait disturbance, increased fall risk, memory impairment, movement disorders, sedation, orthostatic/postural and withdrawal hypotension;⁵²
- An increase in **emotional turmoil**, sense of abandonment, loss of control and disorientation;⁵³

⁴⁶ Adelaide Night and Day Family Therapy, *Tied Up in Knots: Systemics, Occupational Therapy and Restrictive Practices* (April 2011) <https://adelaidetherapy.com/tied-up-in-knots-systemics-occupational-therapy-and-restrictive-practices/>.

⁴⁷ Amaze, *Position Statement – Restrictive Practices* (March 2018) <https://www.amaze.org.au/wp-content/uploads/2019/06/Amaze-Restrictive-Practices-March-2018.pdf> 2.

⁴⁸ Australian Psychological Society, *Evidence-based guidelines to reduce the need for restrictive practices in the disability sector* (2011) <https://www.psychology.org.au/getmedia/c986ad95-d312-4b2c-89da-3157b215f118/Restrictive-Practices-Guidelines-for-Psychologists.pdf> 8; Department of Health and Human Services, *Assisting mental health services to reduce restrictive practices: A case study about the role of the Victorian Department of Health and Human Services* (September 2018)

<https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwj8-ie1fPpAhV2zzqGHSq5D0gQFjABegQIBRAB&url=https%3A%2F%2Fwww2.health.vic.gov.au%2FApi%2Fdownloadmedia%2F%257B73FD82C-FA58-4A79-9CA5-05A03FF1521A%257D&usq=AOvVaw10rWC8L1dZJFj6f18qDMkq>.

⁴⁹ Brophy, Roper, Hamilton et al, *Consumers and Carer perspectives on poor practice and the use of seclusion and restraint in mental health settings: results from Australian focus groups* (February 2016) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4744440/>; Pearce and Chesterman, *Submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People With Disability* (March 2020) <https://www.publicadvocate.vic.gov.au/resources/submissions/royal-commission-into-violence-abuse-neglect-and-exploitation-in-disability-care/700-2019-response-to-the-royal-commissions-issues-paper-on-health-care-for-people-with-cognitive-disability/file> 16.

⁵⁰ Krysla Canvin, *Restrain Yourself: Reducing Restrictive Practices on Mental Health Wards* (ND) <https://www.nationalelfservice.net/populations-and-settings/secondary-care/restrain-yourself-reducing-restrictive-practices-on-mental-health-wards-bctcompare/>.

⁵¹ Grant Everett, *Dr Jeffrey Chan asks: Can we end restraint and seclusion in Australia?* (April 2019) <https://panoramaonlinemagazine.com/2019/04/28/dr-jeffrey-chan-asks-can-we-end-restraint-and-seclusion-in-australia/>; Daniel Rippon, *The Impact of Restrictive Practices on the Well-being of Care Staff* (February 2019) <https://www.studio3.org/post/the-impact-of-restrictive-practices-on-the-well-being-of-care-staff>.

⁵² Health Information and Quality Authority, *Literature Review – Restrictive Practices* (December 2017) https://www.hiqa.ie/sites/default/files/2020-03/Restrictive-Practices_Literature-Review.pdf 12.

⁵³ Melbourne Social Equity Institute, *Seclusion and Restraint Project Report* (August 2014) https://socialequity.unimelb.edu.au/_data/assets/pdf_file/0017/2004722/Seclusion-and-Restraint-report.PDF 90.

- **Physical ill-health and injury**, including sedation, falls, fractures, risk of thromboembolic and cerebrovascular events, arrhythmia and QT prolongation, neuroleptic hypersensitivity associated with Dementia, aspirational pneumonia, decreased seizure threshold, Parkinson's-like syndrome brought on by drugs, akathisia and tardive dyskinesia;⁵⁴
- **Physical impacts**, including direct skin injuries, pressure injuries, contractures, respiratory complications, urinary and faecal incontinence, constipation, under-nutrition, impaired muscle strength and balance, reduced cardiovascular endurance;⁵⁵
- **Legal costs** from potential liabilities in the event that Restrictive Practices are applied excessively or someone is injured as a consequence of their use.⁵⁶

In short, there is a plethora of research detailing the negative consequences of Restrictive Practices.⁵⁷ They are highly distressing for the person with a disability and it is difficult to find any evidence to support the successful use of Restrictive Practices in the literature. According to a National Mental Health Commission review, no randomised studies exist which evaluate the value of seclusion or restraint in people with a serious mental illness. Furthermore, it should be noted that the literature that does exist mostly focuses on the use of Restrictive Practices in inpatient units and emergency departments, with only limited sources focusing on community, custodial and ambulatory settings where Restrictive Practices are widely applied to people with disability.⁵⁸

The use of Restrictive Practices has also been shown to lead to further abuse, neglect and exploitation of people with disability. According to researchers:

Disability can increase one's vulnerability to abuse. For example, children with any type of disability are 3.44 times more likely to be a victim of some type of abuse as compared to children without disabilities. Of all types of disability, children with behaviour disorders and children with intellectual disability are both at an increased risk for all three forms of abuse (neglect, physical and sexual abuse) compared to children with other types of disabilities (speech/language, hearing impairments).⁵⁹

The traumatic effects of Restrictive Practices mean that when people with disability are corralled into spaces with little control and choice by individuals who are exercising power and dominance over them, a natural instinct can be to become violent as a form of protest. This is particularly so when the person applying the Restrictive Practice uses force. As Dr Spivakovsky testified, Restrictive Practices blur the line that separates violence from socially permissible behaviour.⁶⁰

⁵⁴ Carmelle Peisah, *Inquiry into Elder Abuse – Supplementary Questions to Carmelle Peisah* (April 2016) <https://www.parliament.nsw.gov.au/lcdocs/other/9995/Answers%20to%20questions%20on%20notice%20and%20supplementary%20answers%20-%20Professor%20Carmelle%20Peisah.PDF> 2-3.

⁵⁵ Royal Commission into Aged Care Quality and Safety, *Restrictive Practices in Residential Aged Care in Australia* (May 2019) <https://apo.org.au/sites/default/files/resource-files/2019-05/apo-nid233756.pdf> 9-11.

⁵⁶ J Chan et al (2012) 'The dollars and sense of restraints and seclusion' *Journal of Law and Medicine*, September 2012

⁵⁷ National Institute for Intellectual Disability Studies, *What is Restrictive Practice and When is it OK to use a Restraint Procedure?* (2019) <https://niids.ie/2019/04/what-is-restrictive-practice>.

⁵⁸ National Mental Health Commission, *A Case For Change: Position Paper on Seclusion, Restraint and Restrictive Practices in Mental Health Services* (May 2015) <https://www.mentalhealthcommission.gov.au/getmedia/63e1d2e6-79fe-45ea-aeab-145f1d9b269a/Position-paper-on-seclusion-and-restraint>.

⁵⁹ Adelaide Night and Day Family Therapy, *Tied Up in Knots: Systemics, Occupational Therapy and Restrictive Practices* (April 2011) <https://adelaidetherapy.com/tied-up-in-knots-systemics-occupational-therapy-and-restrictive-practices/>.

⁶⁰ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Transcript* (December 2019) <https://disability.royalcommission.gov.au/publications/transcript-3-december-2019> 22.

Are current approaches to Restrictive Practices effective? Are there any gaps in the current approaches?

There is very little evidence to support the use of Restrictive Practices as being effective measures in addressing and reducing behaviours of concern. For example, Webber et al note that “...overall, the evidence in favour of chemical restraint for controlling behaviours of concern such as aggression, is weak”.⁶¹ This is concerning given the widespread use of chemical restraint for people with a disability over extended periods of time, with little or no data collected to demonstrate its efficacy. They conclude, “Our available data to date suggests that restrictive interventions do not lead to reduction in the occurrence of behaviours of concern except in the short term (i.e. while applied) and that what is needed is a better understanding of the functions of behaviours of concern and the individual needs of the person and interventions that address those functions and needs.”⁶² QAI is concerned about the suppression of purposeful attempts at communication in these situations and is therefore of the position that the current approach to the use of Restrictive Practices is ineffective.

In addition to the lack of efficacy regarding the use of Restrictive Practices, current legislative protections available for Queenslanders are also ineffective in protecting against the unlawful and inappropriate use of Restrictive Practices. Firstly, rules contained in the *Disability Services Act 2006* (Qld) apply to disability service providers but not to government bodies such as Education departments who routinely sanction the use of Restrictive Practices against students with a disability. Similarly, individuals may only be covered by the (limited) protections under the legislation if they are NDIS participants, however individuals that do not or have not met access cannot rely upon the safeguards in the regime, despite suffering identical human rights violations.⁶³ For example, individuals living in hostels or boarding houses that are privately funded are not protected under the legislation. The rules also only apply to individuals with an identified intellectual or cognitive impairment, and yet individuals with physical disabilities are also subjected to Restrictive Practices. This fragmented approach, in which certain Restrictive Practices require authorisation from the state’s Department of Communities, Disability Services and Seniors, whilst others require authorisation from the Office of the Public Guardian, creates confusion and adds complexity to an already strenuous situation. This piecemeal approach also means that some people with disability are subjected to Restrictive Practices that are unregulated and which do not fall under the vigorous oversight required when a person’s human rights are at stake. Indeed the use of *unregulated* Restrictive Practices has been identified as a concern by the United Nations Committee on the Rights of Persons with Disabilities (UNCRPD) who recommended the development of an:

*“...independent national preventive mechanism to monitor places of detention - such as mental health facilities, special schools, hospitals, disability justice centres and prisons - in order to ensure that persons with disabilities, including psychosocial disabilities, are not subjected to intrusive medical interventions.”*⁶⁴

⁶¹ Lynne Webber, Frank Lambrick, Mandy Donley et al., ‘Restraint and Seclusion of People on Compulsory Treatment Orders in Victoria, Australia in 2008-2009’ (2010) 17(4) *Psychiatry, Psychology and Law* 562, 564.

⁶² *Ibid* 572

⁶³ Queensland Advocacy Incorporated, *Australian Human Rights Commission OPCAT in Australia* (July 2017)

https://humanrights.gov.au/sites/default/files/09.%20QAI%20OPCAT%20submission%2019%20July%202017.pdf?_ga=2.156145855.587831650.1592184148-998228770.1549418566 11.

⁶⁴ Committee on the Rights of Persons with Disabilities, ‘Concluding Observations on the Initial Report of Australia, Adopted by the Committee at Its Tenth Session (2–13 September 2013)’ (United Nations, 4 October 2013) [35]—[36]; Michael Williams, John Chesterman and Richard Laufer, ‘Consent vs Scrutiny: Restrictive Liberties in Post-Bournewood Victoria’ (2014) 21 *Journal of Law and Medicine*.

Secondly, there have been two legislative amendments that have arguably eroded the legislative protections contained in the *Disability Services Act 2006* (Qld). In response to the Carter report and the harrowing accounts of human rights violations contained therein, the Queensland government introduced the *Disability Services and Other Amendment Act 2008* (Qld) to increase the protection offered to people with a disability by increasing the regulation of the use of Restrictive Practices for persons who exhibit behaviours of concern. Whilst the legislative framework was indeed strengthened, it has since been eroded with the extension of the time period in which Restrictive Practices under short-term approvals can be used, doubling the duration from three to six months. Most people would find the imposition of any restriction upon their person or life to be unendurable for one day, let alone six months. Given the fundamental infringement of a person's human rights brought about by the application of a Restrictive Practice, the lack of procedural fairness inherent in the sanctioning of short-term approvals is a significant cause for concern. The other troubling amendment is the extension of immunity afforded to service providers. Service providers implementing Restrictive Practices who can show they acted honestly and without negligence when there are delays in obtaining approval or consent are provided immunity from civil and criminal liability. This is a broad protection that essentially authorises actions that would otherwise amount to a contravention of the criminal law (for example, false imprisonment or assault). Prior to the introduction of the immunity provision, service providers were adequately protected by the common law doctrine of necessity and by workplace health and safety legislation.⁶⁵

Thirdly, whilst there have been genuine attempts to increase the regulation of Restrictive Practices in certain contexts, such as the requirement for Positive Behaviour Support Plans to accompany the use of Restrictive Practices for NDIS participants, the legislative mechanisms providing these safeguards offer only procedural rather than substantive protections. That is, they may change the bureaucratic processes required of service providers who seek to restrict the liberties of their participants, but they do not address the wider contextual issues at play, such as the power imbalance between the individual and their service provider, the inadequacy of their support services or the lack of sufficient independent oversight. Indeed, guidelines provided by the Department of Communities, Disabilities and Seniors make only very brief reference to the need for service providers to explore less restrictive options prior to resorting to Restrictive Practices.⁶⁶ They also fail to place the issue within a human rights framework by highlighting the importance of advocacy or legal representation for the individual concerned.

Fourthly, Positive Behaviour Support Plans (PBSPs) for NDIS participants who are subjected to Restrictive Practices have not provided the panacea of protection originally anticipated by policy makers. A lack of creativity, skill and vision can characterize the content of a PBSP, often accompanied by a lack of funding to implement the strategies suggested, a lack of data collected to monitor the effectiveness of the strategies suggested, a lack of modification to the PBSP based upon this data and a lack of skill among the workforce to apply the strategies and the theory behind them. This, combined with the perceived 'toothless' approach of the NDIS Quality and Safeguards Commission, means that opportunities to successfully reduce or eliminate the use of Restrictive Practices are being missed.

⁶⁵ Queensland Advocacy Incorporated, *Conclusions on the Use of Restrictive Practices for People with an Intellectual or Cognitive Impairment* (October 2014) <https://qai.org.au/wp-content/uploads/2017/10/Final-QAI-conclusions-on-the-use-of-RP-October-2014-final-version-2.pdf>

⁶⁶ <https://www.communities.qld.gov.au/resources/dcdss/disability/service-providers/centre-excellence/authorising-restrictive-practices.pdf>

Fifthly, the current legislation is founded upon the assumption that people with disability can and ought to change their behaviour, focusing erroneously on the individual alone rather than their wider environment. Whilst reference is made within the *Disability Services Act 2006* (Qld) to the human rights that belong to people with disability, this reference appears to be declaratory only, insofar as the subsequent absence of any provisions that translate these rights into practice. There appears to be a lack of impetus to drive the development of meaningful strategies that ensure the use of Restrictive Practices is avoided or measures to hold service providers applying Restrictive Practices to account.

Despite the *Human Rights Act 2019* (Qld) theoretically providing additional legislative protection of the human rights contained within it, there are currently no decided cases considering whether the use of Restrictive Practices will be considered a limitation that “is reasonable and demonstrably justifiable in a free and democratic society based on human dignity, equality and freedom”.⁶⁷ The Act does however provide another layer of considerations necessary before Restrictive Practices are to be used and provides another mechanism for review and regulation of these practices. Unfortunately, these measures are not available to all Australians and illustrate how human rights protection is something of a post-code lottery for people with disability in Australia. A federal Charter of Human Rights would help address this gap and extend a human rights framework, so important when fundamental issues of personal liberty and freedom are at stake, to all Australians.

In light of what is at stake for individuals subjected to Restrictive Practices, it is critical that safeguards are in place to ensure any decisions to impose Restrictive Practices are transparent, open to independent scrutiny and are reviewable by an independent body. It is also critical that reporting and data collection obligations are accompanied by mandatory training of service providers and staff who fail to meet the goal of reducing or eliminating the use of Restrictive Practices, and ultimately the removal of those staff when continued failure to comply with the targeted reduction occurs.⁶⁸

Despite the theoretical protections contained within the legislation and its focus on reducing Restrictive Practices, the experiences of people with disability paint a very different picture. The fractured regulatory system and its heavily bureaucratized processes leave the issue of Restrictive Practices in something of an identity crisis. If we are to truly remove and eliminate the use of Restrictive Practices on people with disability, why are we increasing measures to sanction their ongoing use and acquiescing to requests from service providers to reduce ‘red tape’?

Absent from these policy deliberations are the voices of people with disability. For example, the removal of the ‘Locked gates, doors or windows’ policy from the Restrictive Practices legislation occurred without any consultation with the disability community, who would have likely raised legitimate fears about the lack of adequate oversight for people with disability who continue to be subjected to this type of confinement. There must be greater consultation with and involvement of people with disability at the policy level in order to ensure concepts born of ableism do not continue to dominate our legislative discourse.

⁶⁷ Explanatory Notes, *Human Rights Bill 2018* (Qld) page 5.

⁶⁸ Queensland Advocacy Incorporated, *Conclusions on the Use of Restrictive Practices for People with an Intellectual or Cognitive Impairment* (October 2014) <https://gai.org.au/wp-content/uploads/2017/10/Final-QAI-conclusions-on-the-use-of-RP-October-2014-final-version-2.pdf>

How can the use of Restrictive Practices be prevented, avoided or minimised?

As we have seen, the use of Restrictive Practices is less to do with the behaviour of the individual concerned and more to do with the *relationship* between the individual and their environment. That is, the extent to which the individual is disempowered by those around them, devalued by their service providers and subjected to discriminatory attitudes due to their disability. The relationship between the individual and their environment must therefore be the focus of efforts that aim to eliminate and reduce the use of Restrictive Practices.

Michael Kendrick's work on exploring the ethics of 'right relationships' for people with disability identifies an ethical framework for interpersonal and impersonal relationships that can act as a safeguard against the rising dominance of human service organisations.⁶⁹ Kendrick identifies the following features as integral to the development of these relationships:

- Creating service delivery arrangements that permit service users sufficient power to be able to meaningfully shape how service is rendered;
- Helping individuals to recognise that they can personally embody 'right relationship' ethics in how they relate to the people they assist, irrespective of the bureaucratic structures in which they work, and be prepared to uphold the cost of 'right relationship' ethics;
- Keeping services as small, 'grass roots' and non-bureaucratized as possible;
- Favouring flexible and personalised approaches over standardised ones;
- Relating 'with' people, not 'at', 'on', or 'down' to them;
- Negotiating with people, rather than imposing answers;
- Creating mutual and shared ideals of what the 'right relationship' is;
- Rejecting the theory of professional or managerial ultimacy over service;
- Relating to each person as unique in the design and operation of services; and
- Leaving core decisions of a personal nature to the person concerned.

The literature also provides examples of effective strategies that prevent, avoid or minimize the use of Restrictive Practices. For example, empirical research from Winchester, United States, highlights the success of strategies aimed at minimising the use of physical restraints on people with disability and the resulting reduction in 'challenging behaviours' exhibited. Information was gathered to obtain a clear understanding of the disability support workers' feelings about the initiative to minimize physical restraint. Training was provided regarding philosophical issues as well as how to utilize a new tool/procedure to keep everyone safe during aggressive outbursts. Presence by the management team was increased to support employees and encourage newly trained techniques. Finally, a formal system of processing was put in place to learn from each restraint in order to prevent the situation in the future. The Winchester Region reduced the use of physical restraint by 99.4% and client-induced employee injuries by 37.7%.⁷⁰

When the approach is changed, by empowerment and ensuring a person with disability is scaffolded by support from the right relationships, the perspective on that person can change from a negative to a positive one and their status can be elevated to equal citizenship. When

⁶⁹ Kendrick, Michael, 'Some Initial Thoughts On Establishing "Right Relationship" Between Staff, Professionals, Service Organisations and the People They Assist' QAI Newsletter, April 2000

⁷⁰ Kim Sanders, 'The Effects of an Action Plan, Staff Training, Management Support and Monitoring on Restraint Use and Costs of Work-Related Injuries', (2009) 22(2) Journal of Applied Research in Intellectual Disabilities 216.

perceptions and expectations are changed, our approaches, behaviours and responses also implicitly change. When we remove the burdens we place upon people, they can flourish and respond accordingly. When an approach of respect, autonomy and enablement is integrated with the practical safeguards required by people with disability, we return control and respect and reduce or remove the use of Restrictive Practices.

In order to make this transition, we must continue the ideological shift in Australia from the substitute decision-making model for individuals with impaired capacity to the supported decision-making model. A supported decision-making model empowers a person to make their own decisions with appropriate assistance provided by a supporter who assists the individual to understand and communicate their decision. Rather than using the notion of incapacity as a threshold test, a key feature of guardianship regimes, the supported decision-making model is based on the assumption that the role of the supporter is to assist in *developing and/or maintaining* the person's capacity, taking a more nuanced approach to the issue of capacity that aims at enhancing autonomy. This position is consistent with international humanitarian law and with contemporary sociological approaches to autonomy. QAI considers that by helping to develop decision-making capacity and respecting autonomous choice, supported decision-making decreases the incidence of communicative behaviours that may lead to the application of Restrictive Practices.

QAI considers that everyone, regardless of whether they have a disability, should be supported to express their views and preferences, however ill-conceived they may appear to be and regardless of whether the decision is deemed to align with their perceived best interests. Expressing individual preferences is an essential aspect of individual identity and exercising ownership of the decision-making process is fundamental to human dignity. There must be sufficient time, dedication and support devoted to providing the person with all the information and assistance they need in order to make their own decisions. They must be afforded the life experiences required to contextualise and understand the consequences of their decision-making. The legal right of people with disability to make their own decisions should only ever be interrupted in extraordinary circumstances. As Kayess and Fogarty argue, the CRPD has been instrumental in shaping the perspective that *difficulty* in making or communicating a decision is not the same as an *inability* to do so.⁷¹

In keeping with this model, when, in the rare and exceptional circumstances in which the use of Restrictive Practices cannot be avoided, the person subjected to the restraint must be involved in the decision-making regarding the use of a Restrictive Practice. The person with disability must be scaffolded with appropriate support from the right relationships to participate in the decision-making, an approach that both upholds their human rights and dignity as well as leads to the reduction and elimination of the Restrictive Practice in a more timely and humane manner.

The role of informal supports in the success of supported decision-making models has been widely noted in the literature. QAI's vision for normalizing supported decision-making is to encourage and support informal supporters to conduct their support with a sense of morality that respects dignity of risk and allows people with disability to make mistakes, to learn and to truly make their own decisions. QAI's vision also foresees the need for ongoing community education regarding the concept of legal capacity as distinct from any other form of capacity, its

⁷¹ Rosemary Kayess and Ben Fogarty, 'The Rights and Dignity of Persons with Disabilities – A United Nations Convention' (2007) 32 *Alternative Law Journal* 22, 25

fluctuating nature and the role that increased autonomy and control can play in increasing a person's capacity.

Unfortunately, a significant factor leading to sub-optimal treatment of people with disability is that of mindsets and preconceptions. This is an issue that spans the initial interaction between a person with disability and service provider to the eventual application of a Restrictive Practice.⁷² The presumption of legal capacity is enshrined in Article 12 CRPD. Yet people with disabilities, particularly those with intellectual and psychosocial disabilities, have long been subjected to limitations on their right to legal capacity and we are yet to see a substantive shift since ratification of the CRPD. Due to stigma and discrimination, people with disability in many parts of the world continue to be deprived of legal capacity despite being able to make and communicate decisions, either by themselves or with support. The challenge to change mindsets is enhanced by the fact that the group of persons concerned are marginalised and disempowered. They are side-lined, individually and collectively, from the legal, political and bureaucratic processes that govern their day-to-day lives. Indeed they are often not given a voice in many decisions that relate to their fundamental rights, including where and with whom they live.⁷³

As Salzman notes, there is both a judicial and social tendency to "...more readily provide accommodations needed to overcome barriers to physical disabilities than those needed to overcome barriers to mental disabilities."⁷⁴ The bias against people with intellectual and cognitive disabilities and society's ineptitude in adequately supporting must change. We must learn how to support *all* people with disability by becoming comfortable with the diversity within this cohort of individuals, by recognizing the various barriers that they face and by remaining flexible to their changing needs.

The conceptualisation of "behaviours of concern" also of course, warrants analysis. It is QAI's position that the behaviour of people with disability is frequently misunderstood by people without disability and that this plays a significant role in contributing towards the recourse to Restrictive Practices. It is imperative for steps to be taken to try to understand a person's behaviour by understanding their experiences and history, including the quality of current and previous support arrangements and instances of abuse and neglect. People with intellectual impairments often face significant difficulties communicating and this can be aggravated in situations in which they feel unsafe, threatened or disempowered. Behaviour is usually part of a process of attempted communication that has escalated as a consequence of a failure by the service provider to respect the rights of the person to autonomous choice and respect. It is not always easy to get this right – even family members with the best intentions can make mistakes no matter how well they know the person. This does not mean, however, that they or any service provider should merely resort to the use of Restrictive Practices and abandon earnest endeavours to understand the person and to elevate their capacities and status. Measures must be introduced to ensure behaviour is not interpreted out of context or incorrectly labelled as unprovoked aggression or lack of cooperation, which we know leads to the use of Restrictive Practices.

⁷² Queensland Advocacy Incorporated, *Conclusions on the Use of Restrictive Practices for People with an Intellectual or Cognitive Impairment* (October 2014) <https://qai.org.au/wp-content/uploads/2017/10/Final-QAI-conclusions-on-the-use-of-RP-October-2014-final-version-2.pdf>

⁷³ Ibid 46.

⁷⁴ Ibid 47.

What alternatives to Restrictive Practices could be used to prevent or address behaviours of concern?

QAI considers that, in attempting to understand a person's behaviour, it is imperative to start by understanding their life experiences; the environmental, relationship, sensory, mental health and physical factors that may be relevant; any difficulties they may face in communicating; and the situations in which they may feel unsafe, threatened or disempowered. As has already been noted, behaviour can be interpreted out of context and incorrectly labelled as unprovoked aggression justifying seclusion, containment or mechanical or chemical restraint when in fact, the use of Restrictive Practices is associated with an escalation in the manifestation of behaviours of concern, rather than a reduction.⁷⁵

In order to facilitate the necessary understanding, QAI recommends an emphasis on **Positive Behaviour Support** ('PBS'), which has been implemented by numerous organisations in conjunction with Restrictive Practices.⁷⁶ PBS is an approach which includes an ongoing process of research-based assessments, interventions and data-based decision-making that is focussed on building social and other functional competencies, supportive contexts and preventing the occurrence of behaviours of concern. It relies "on strategies that are respectful of a person's dignity and overall well-being and that are drawn primarily from behavioural, educational, and social sciences, although other evidence-based procedures may be incorporated",⁷⁷ and, in many cases, it can reduce behaviours of concern overtime by allowing the clinicians to concentrate on the clients' individual needs and help build their strengths and opportunities".⁷⁸

Other alternatives that will assist with the prevention of or addressing behaviours of concern include:

- The example of the **Massachusetts Department of Mental Health** which, in 2009, discovered that a range of strategies were found to be useful by the patients. The strategies included: using sensory strategies such as comfort rooms, music, coping skills, and blanket wraps; having the support and leadership of peers; creating comfortable environments that feel more like home; having more individual time with staff; allowing appropriate physical contact; conducting community meetings and encouraging participation in activities such as sports, art, and music can be helpful for youth; using strong communication skills and listening skills; encouraging young people to be active and fully engaged in their lives, programs and treatments; using nonjudgmental positive

⁷⁵ Queensland Advocacy Incorporated, *Position Statement Regarding The Use Of Restrictive Practices On People With Disability* (October 2014) <https://www.qai.org.au/wp-content/uploads/2019/11/ATTACHMENT-C-Final-QAI-Position-Statement-Regarding-the-Use-of-Restrictive-Practices.pdf> 2.

⁷⁶ Health Consumers Alliance of South Australia Incorporated, *HCA Response to Review of the Restraint and Seclusion in Mental Health Services Policy Guideline and Associated Documents* (April 2018) <https://www.hcasa.asn.au/documents/731-hca-response-to-review-of-restraint-and-seclusion-policy-guideline/file> 4.

⁷⁷ JFA Purple Orange, *Minimising and Eliminating Restrictive Practices. A Consultation for the ACT Government Final Report* (June 2017) https://purpleorange.org.au/application/files/2715/5735/4860/Minimising_and_Eliminating_Restrictive_Practices_consultation_report_prepared_by_JFA_Purple_Orange_for_ACT_government_final.pdf 24; Clark, Shurmer, Kowara et al, *Reducing restrictive practice: Developing and implementing behavioural support plans* (February 2017) https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/reducing-restrictive-practice/resources/developing-and-implementing-behaviour.pdf?sfvrsn=457d4e64_1.

⁷⁸ Department of Health and Human Services, *A National Measure of Environmental Restraint – Final Report* (June 2019) <https://www.daru.org.au/wp/wp-content/uploads/2019/07/Nous-Group-A-national-measure-of-environmental-restraint-final-report-20-June-2019.pdf> 5; Department of Communities, Child Safety and Disability Services, *Discussion Paper - Review of the Regulation of Restrictive Practices in the Disability Services Act 2006 and the Guardianship and Administration Act 2000* (ND) <https://www.cabinet.qld.gov.au/documents/2013/Jul/Restrictive%20practices/Attachments/Attachment%20-%20review%20of%20the%20restrictive%20practices%20discussion%20paper.PDF> 3.

language and tone of voice and no threatening body language; and respecting confidentiality;⁷⁹

- Combining psychology with the **allied health** disciplines of speech pathology, occupational therapy and physiotherapy – which, together, can increase the quality of an intervention due to their specialist focus on aspects such as adapting the person’s environment, developing meaningful tasks and enjoyable activities; developing skills training plans, specialist assessments, adaptation and making of appliances where mechanical restraint is required to minimise injury to the person and staff training in specialist areas;⁸⁰
- Employing a **recovery-based approach**. “Recovery means working in partnership with people to improve their clinical and social outcomes. Originating in mental health services, recovery models are consistent with contemporary service philosophies across wider health and social care settings and include the promotion of human rights based approaches, enhancing personal independence, promoting and honouring choices and increasing social inclusion. These models are founded on the principle that recovery is possible for everyone. Each person can achieve a satisfying and fulfilling life, in keeping with their own preferences, goals and aims, through empowerment, self-determination and unconditional engagement within wider communities and society more generally. International literature on seclusion and restraint reduction demonstrates that a recovery-focused model is essential for achieving a reduction in the use of restrictive interventions carried out against a person’s wishes”;⁸¹
- Using **preventative measures**, such as advance safety planning, to minimise the use of mechanical restraint by addressing the person’s clinical needs and environmental triggers or verbal strategies and de-escalation techniques to help the person to manage their behaviour of concern without mechanical restraint;⁸²
- Facilitating access to a range of services that, while provided by other sectors, can lead to **optimizing mental health**;⁸³ and
- Supporting and **encouraging family members to advocate** for their relatives, utilizing their wealth of knowledge of the person and their interests, wants and desires and listening to their ideas on how best to support the person with disability.⁸⁴

Whichever alternative this inquiry promotes, it is vital that it recognises the importance of knowing the person with disability and their needs intimately. This should be based on a good understanding of their life experiences and how these have shaped their identity and reputation,

⁷⁹ Adelaide Night and Day Family Therapy, *Tied Up in Knots: Systemics, Occupational Therapy and Restrictive Practices* (April 2011) <https://adelaidetherapy.com/tied-up-in-knots-systemics-occupational-therapy-and-restrictive-practices/>; Department of Health and Human Services, *Assisting mental health services to reduce restrictive practices: A case study about the role of the Victorian Department of Health and Human Services* (September 2018)

<https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKewj8-ie1fPpAhV2zzgGHSq5DOgQFIABegQIBRAB&url=https%3A%2F%2Fwww2.health.vic.gov.au%2Fapi%2Fdownloadmedia%2F%257B73FD82C-FA58-4A79-9CA5-05A03FF1521A%257D&usq=AOvVaw10rWC8L1dZJFj6f18gDMkq> 10.

⁸⁰ Australian Psychological Society, *Evidence-based guidelines to reduce the need for restrictive practices in the disability sector* (2011) <https://www.psychology.org.au/getmedia/c986ad95-d312-4b2c-89da-3157b215f118/Restrictive-Practices-Guidelines-for-Psychologists.pdf> 17.

⁸¹ Department of Health, *Positive and Proactive Care: reducing the need for restrictive interventions* (April 2014) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf 19.

⁸² NSW Communities and Justice, *Restrictive Practice Authorisation: Information For Families* (ND) https://www.facs.nsw.gov.au/_data/assets/pdf_file/0006/775365/Restrictive-Practices-Information-for-families.pdf 3.

⁸³ Pearce and Chesterman, *Submission to the Royal Commission into Victoria’s Mental Health System* (July 2019) <https://www.publicadvocate.vic.gov.au/resources/submissions/mental-health-1/626-opa-submission-to-royal-commission-into-victorias-mental-health-system-05-july-2019/file> 11.

⁸⁴ Elder and Varga, *Submission to the New South Wales Government on Restrictive Practices Authorisation (RPA) in New South Wales* (August 2019) <https://www.family-advocacy.com/assets/Submissions/188f1d3d90/Restrictive-practices-submission-082019.pdf> 7.

how they are perceived by their family, services, workers, peers and society at large.⁸⁵ As the National Mental Health Commission has stated, 90% of participants in its 2015 survey indicated that taking such an approach to address Restrictive Practices would be extremely effective at reducing the negative effects of seclusion and restraint.⁸⁶ The new model must incorporate consultation with key support staff, customers and frontline specialists who would be collaborating to reduce and eliminate the use of Restrictive Practices.⁸⁷ Most importantly however, it must involve the consultation of people with disability. Because they are the experts in their own lives. And any policy-making that affects people with disability must start with them.

Conclusion

In light of the lack of evidence supporting the efficacy of Restrictive Practices in addressing behaviours of concern and the undeniable harm that they cause, QAI considers it to be inconceivable that such practices are used on people with disability in all corners of society. QAI thanks the Royal Commission for the opportunity to contribute to this inquiry and is happy to provide further information or clarification of any of the matters raised in this submission upon request.

⁸⁵ Peter Millier, *Positive Behaviour Framework: Restrictive Practice(s) Issue Paper* (October 2011)

<http://www.disability.wa.gov.au/Global/Publications/For%20disability%20service%20providers/Guidelines%20and%20policies/Behaviour%20Support/Restrictive%20Practices%20Issues%20Paper.pdf> 16-17.

⁸⁶ National Mental Health Commission, *A Case For Change: Position Paper on Seclusion, Restraint and Restrictive Practices in Mental Health Services* (May 2015) https://www.mentalhealthcommission.gov.au/getmedia/63e1d2e6-79fe-45ea-aeab-145f1d9b269a/Position-paper-on-seclusion-and-restraint_20.

⁸⁷ Northcott, *On the journey to reduce restrictive practices* (October 2019) <https://northcott.com.au/on-the-journey-to-reduce-restrictive-practices/>.