

Submission by



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

To Community Support and Services Committee

5th July 2024

About Queensland Advocacy for Inclusion

Queensland Advocacy for Inclusion (QAI) is an independent, community-based advocacy organisation and community legal service that provides individual and systems advocacy for people with disability. Our purpose is to advocate for the protection and advancement of the needs, rights, and lives of people with disability in Queensland. QAI's Management Committee is comprised of a majority of persons with disability, whose wisdom and lived experience guides our work and values.

QAI has been engaged in systems advocacy for over thirty years, advocating for change through campaigns directed at attitudinal, law and policy reform.

QAI also provides individual advocacy services in the areas of human rights, disability discrimination, guardianship and administration, involuntary mental health treatment, criminal justice, NDIS access and appeals, and non-legal advocacy for young people with disability including in relation to education. Our individual advocacy experience informs our understanding and prioritisation of systemic advocacy issues.

Since 1 January 2022, QAI has also been funded by the Queensland Government to establish and co-ordinate the Queensland Independent Disability Advocacy Network (QIDAN). QIDAN members work collaboratively to raise the profile of disability advocacy while also working towards attitudinal, policy and legislative change for people with disability in Queensland.

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QAI's recommendations

1. Amend the proposed authorisation framework to ensure it applies to all settings in which people with disability are subjected to restrictive practices, including residential service providers accredited under the *Residential Services (Accreditation) Act 2002*.
2. Enhance checks and balances on the appointment of the Senior Practitioner to ensure they do not make decisions in an overly paternalistic way. For example, require the Senior Practitioner to consider the human rights listed in section 18 when making a decision to authorise a restrictive practice and require them to report how their decisions impact on human rights.
3. Consider the cultural safety of the Senior Practitioner model for First Nations people with disability and engage in further consultation with First Nations people with disability and their representative organisations.
4. Provide people with disability who are subjected to authorised restrictive practices with automatic legal representation that is free and not means tested.
5. Ensure that expert evidence from a multidisciplinary team of clinicians is gathered as part of developing behaviour support plans, particularly in circumstances where a service provider seeks to contain or seclude a person with disability.
6. Include the right to freedom from torture or cruel, inhuman or degrading treatment or punishment as a supporting right to the human rights principle stated in clause 18.
7. Add the word 'serious' so that the Bill states that restrictive practices can only be used as a last resort, in response to a *serious* risk of harm to a person with disability or others, at relevant clauses.
8. Explicitly include reference to the need for people with disability to have access to supported decision-making.
9. Clarify which restrictive practices are to be prohibited and include them in legislation rather than regulation.
10. Introduce a provider of last resort with regards to the preparation of positive behaviour support plans.

11. Introduce penalties for service providers who fail to adhere to positive behaviour support plans.
12. Regulate which staff members at a service provider can implement restrictive practices. For example, require that only staff members with certain training, qualifications and/or experience can implement restrictive practices.
13. Require the team working alongside the Senior Practitioner to include people with lived experience of disability and restrictive practices.

Introduction

QAI welcomes the introduction of the *Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2024 (the Bill)* and the Queensland Government's commitment to improving the regulatory framework authorising the use of restrictive practices.

As the Minister acknowledged, “restrictive practices are used too often and sometimes inappropriately”¹ and “can have substantial impacts on the rights and freedoms as well as the physical and emotional wellbeing” of the person subjected to them.

During the Bill's explanatory speech, the Minister cited the findings of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (**Disability Royal Commission**) as a key reason for introducing this Bill into parliament. However, while the Bill introduces some welcome changes, QAI is disappointed to see that it falls short of the recommendations made by the Disability Royal Commission (see Recommendations 6.35-6.41); recommendations that many in the sector consider to be moderate, at best.²

While QAI supports the introduction of a Senior Practitioner model, its implementation will present its own challenges. For example, how culturally safe is the Senior Practitioner model for First Nations people with disability? And what safeguards will ensure that the person occupying the role does not make decisions in an overly paternalistic way?

Enhancing rights, including review and appeal rights for authorisation decisions, is important. However, new rights introduced by the Bill must be accompanied by additional support avenues for people with disability to exercise and enforce them. Accountability is fundamental to ensuring restrictive practices are only used as a last resort measure within a framework that is genuinely trying to work towards reducing and eliminating their use.

¹ Hon C Mullen, Explanatory Speech, 14 June

² See for example, [analysis by DANA](#) which said “Crucially, none of the recommendations call for the elimination of restrictive practices, nor outline a path to ending them”

QAI's submission will discuss the following:

1. Positive changes introduced by the Bill
2. Issues for consideration by the Committee
3. Amendments required to enhance safeguards for people with disability.

1. Positive changes introduced by the Bill

QAI welcomes the improvements to the authorisation framework for restrictive practices introduced by this Bill, many of which QAI has recommended for some time. These include:

- Expanding the scope of Queensland's restrictive practices authorisation framework to include all people with disability, including children with disability and persons with disabilities other than intellectual or cognitive disability.
- Aligning Queensland's restrictive practice definitions with those in the National Disability Insurance Scheme (**NDIS**) Rules. For example, including locked gates, doors, and windows as a regulated restrictive practice outside of the NDIS setting.
- Legislating a complete prohibition on certain types of restrictive practices.
- Introducing review and appeal rights for all authorisation decisions, with avenues to seek merits review at the Queensland Civil and Administrative Tribunal (QCAT).
- The introduction of an administrative model of authorisation through the establishment of the Office of the Senior Practitioner and the removal of the consent-based model of authorisation.
- Greater national consistency in authorisation processes based on the principles for nationally consistent restrictive practices authorisation processes (the National Principles).

2. Issues for consideration by the Committee

While many of the changes are welcome, the implementation of a new authorisation regime will present new challenges. Current problems might persist and a lack of adequate oversight will continue to see people with disability having their human rights infringed.

QAI therefore recommends the Committee consider the following:

Will the new framework apply to supported accommodation settings?

The recent inquiry into the provision and regulation of supported accommodation in Queensland noted stakeholder concern about restrictive practices being used in level 3 residential services.³ The Public Advocate states that the extent to which restrictive practices are used in these settings is unknown and that the appropriateness of their authorisation is unclear.⁴

In the inquiry's final report, the Community Support and Services Committee noted the *Positive Behaviour Support and Restrictive Practices Review* being undertaken by the Department of Child Safety, Seniors and Disability Services, which has culminated in the current Bill. The Committee stated:

We encourage the DCSSDS to continue with this important work, and to give due consideration to the current regulatory complexity around the use of restrictive practices as it pertains to level 3 residential services. We have received evidence of the harm that can result from poorly administered restrictive practices and the physical and emotional damage that results.⁵

While the Committee provided its support for the introduction of a Senior Practitioner model, it did not provide any guidance or make recommendations to address the current gap in authorisation processes that results in residential service providers only being required to

³ Inquiry into the provision and regulation of supported accommodation in Queensland, page 60

⁴ Public Advocate (Qld), 'Safe, secure and affordable'? *The need for an inquiry into supported accommodation in Queensland*, August 2023, page 46

⁵ Inquiry into the provision and regulation of supported accommodation in Queensland, page 62

report on and seek authorisation for the use of restrictive practices in relation to residents *who are also NDIS participants*. This means that residential service providers can use restrictive practices on residents who are not NDIS participants without needing to comply with Queensland’s authorisation framework.

The Committee’s quoted statement above seems to infer that “*the current regulatory complexity around the use of restrictive practices as it pertains to level 3 residential services*” would be addressed by the Department of Child Safety, Seniors and Disability Services in the present review of the restrictive practices authorisation framework and the current Bill before the Committee. However, neither the Bill nor the Explanatory Memorandum mentions accredited residential service providers. This means that the current gap in authorisation processes will continue to exist and that a significant cohort of residents in supported accommodation will continue to be at risk of and be subjected to unauthorised and unregulated restrictive practices, with no oversight and no safeguards in place.

The Disability Royal Commission clearly stated:

*States and territories should have legal frameworks in place providing that a person with disability cannot be subjected to restrictive practices, except in accordance with procedures for authorisation, review and oversight established by law.*⁶

Given the Queensland Government’s commitment to reforming the supported accommodation sector, as well as its commitment to improving the authorisation framework for the use of restrictive practices, it would be a great travesty to allow both inquiries to conclude without either one of them having addressed this critical issue.

What safeguards will ensure the Senior Practitioner does not make overly paternalistic decisions?

Outside of the appeal process, what safeguards will ensure that the person appointed as Senior Practitioner does not approach decision-making in an excessively risk-averse and

⁶ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Final report, Volume 6, Enabling autonomy and access, September 2023, pp 506

paternalistic manner? How long will their appointment be for? We are generally supportive of the transition towards an administrative model of authorisation, whereby a Senior Practitioner undertakes functions such as providing authorisation for restrictive practices. However, depending upon who is appointed to the role and what their values are, concentrating decision-making power with a single individual could see oppressive decisions being made about the use of restrictive practices on people with disability.

Relatedly, what improvements regarding data collection will accompany these changes? And how closely will trends in the use of restrictive practices be monitored following the implementation of this new model?

Clause 183 also provides that complaints about restrictive practices and behaviour support plans can be made to the Senior Practitioner, and that the “Senior Practitioner must maintain a system that deals effectively with complaints received.”⁷ However, this is extremely vague and does not stipulate key procedural fairness requirements such as requiring the Senior Practitioner to respond to the complaints in a timely manner.

To what extent will the use of authorised restrictive practices be proactively monitored by the Senior Practitioner?

While improving the authorisation process is essential, it is insufficient to work towards the reduction and ultimate elimination of the use of restrictive practices on people with disability. QAI continues to encounter service providers who do not understand when their conduct constitutes a restrictive practice and who fail to appropriately report their use. How will these issues be addressed by the new model? The NDIS Quality and Safeguards Commission is seemingly limited in its capacity to proactively monitor and oversee the use of restrictive practices and cannot be relied upon solely to fulfil this function.

⁷ Clause 183(2) of the Bill

How culturally appropriate is the Senior Practitioner model for First Nations people with disability?

How will cultural safety be embedded into this model? Moving authorisation decisions away from guardians and families will likely have additional consequences for First Nations families. The perspective of First Nations communities and their legal representatives must be central to any changes to the current model. QAI recommends the Committee consult further with appropriate representatives of Aboriginal and Torres Strait Islander communities. Culturally safe practice is essential and must be a legislated requirement of any authorisation model.

How will people with disability be supported to exercise their review and appeal rights?

Review and appeal rights, while crucial, can be futile if not accompanied by additional resources and support for people to exercise and enforce them. People with disability who are subjected to the use of restrictive practices must have access to automatic legal representation that is free and not means-tested. Ensuring access to legal representation will help ensure the will, preferences, and rights of people with disability remain central to decision-making regarding the use of restrictive practices. Resources for this must therefore be prioritised in the implementation of the new regime.

Will behaviour support plans take a multidisciplinary approach?

Will the new approach ensure that expert evidence from a multidisciplinary team of clinicians is gathered as part of developing behaviour support plans, particularly in circumstances where a service provider seeks to contain or seclude a person with disability?

The Explanatory Memorandum states:

For both NDIS supports or services and state disability services, the Bill removes the requirement for the Chief Executive, Disability Services, to decide whether a

*multidisciplinary assessment will be conducted in circumstances where a relevant service provider wishes to contain or seclude a person with disability.*⁸

The Bill refers to the requirement for “comprehensive” behaviour support plans to be developed. However, it does not stipulate the level of evidence required to inform the development of these plans and we are concerned that the new regime will lose the collaborative and multidisciplinary approach to informing behaviour support plans that currently exists for plans that include containment and seclusion.

3. Amendments required to enhance safeguards for people with disability

Include the right to be protected from torture and cruel, inhuman or degrading treatment

QAI welcomes the amendments to section 18 of the *Disability Services Act 2006* and the intention to more closely align this section with the general principles of the Convention on the Rights of Persons with Disabilities (CRPD).⁹ We note that the ‘supporting rights’ listed in clause 18(2) in the Bill are not limited to only the general principles in Article 3 of the CRPD but include additional rights such as the right to privacy and the right to liberty.

QAI strongly recommends that the right to freedom from torture or cruel, inhuman or degrading treatment or punishment is also included as a supporting right to the principle stated in clause 18(1). The Queensland Human Rights Commission has stated that the right to freedom from torture or cruel, inhuman or degrading treatment could be engaged in acts that “*cause a person serious physical or mental pain or suffering or humiliate them*”.¹⁰ Given the nature of the restrictive practices regulated by the

⁸ Explanatory Memorandum, page 5

⁹ Article 3 of the Convention on the Rights of Persons with Disabilities (CRPD)

¹⁰ <https://www.qhrc.qld.gov.au/your-rights/human-rights-law/right-to-protection-from-torture-and-cruel,-inhuman-or-degrading-treatment>

authorisation framework and the likelihood that the person subjected to them will suffer pain, suffering or humiliation, the inclusion of this right is essential to ensuring that a person's rights are only ever infringed when it is reasonable and demonstrably justified in a free and democratic society. Similarly, we recommend the right to be free from violence, abuse, neglect and exploitation be included within this section.

Require the Senior Practitioner to consider the human rights principle

While the inclusion of supporting rights in clause 18 of the Bill is welcome, QAI considers that greater reference to the human rights listed should be made throughout the rest of the Bill. This would help to ensure it is not a tokenistic gesture but is instead embedded into the authorisation decision-making framework.

For example, clause 158 lists the circumstances which must be met before the Senior Practitioner can decide to authorise a restrictive practice. Clause 159 lists the matters which the Senior Practitioner must consider when deciding an application. Presently, neither clause refers to the human rights mentioned in clause 18. QAI recommends that both clauses, and others, include reference to and require consideration of the human rights principle in clause 18. The Senior Practitioner should also be required to report against the human rights principle and the extent to which a decision to authorise a restrictive practice upholds the human rights stated in clause 18.

Similarly, behaviour support plans should expressly require information about the extent to which the restrictive practice engages and infringes the person's human rights. This requirement should be added to clause 178, for example.

Change 'harm' to 'serious harm'

Despite some of the Bill's changes reflecting recommendations made by the Disability Royal Commission, such as the introduction of a Senior Practitioner model, they do not fully reflect the recommendations in their entirety. In her explanatory speech, Minister Mullen said that the Bill introduces the "highest standards of safeguards for people with disability".¹¹

¹¹ Hon C Mullen, Explanatory Speech, 14 June, page 2371

However, QAI notes a key discrepancy between the Disability Royal Commission's recommendations and the current Bill.

Recommendation 6.35 of the Disability Royal Commission recommended legal frameworks state that restrictive practices should only be used as a last resort, in response to a *serious risk of harm* to a person with disability or others. The Bill however, uses the language 'as a last resort to prevent *harm* to the person or others.'¹² The threshold for authorising restrictive practices is therefore lower in the Bill and cannot be said to be offering the highest standards of safeguards for people with disability.

Supported decision-making

The Disability Royal Commission also stated that legal frameworks should ensure restrictive practices are only used as a last resort, in response to a serious risk of harm and *only after other strategies, including supported decision-making, have been explored and applied*. QAI recommends including this important additional wording.

Clause 160 also states the Senior Practitioner's requirement to "consult with and consider any expressed or demonstrated views, wishes and preferences of the person with disability". This section should explicitly include a requirement on the Senior Practitioner to resource and facilitate the person with disability accessing support for decision-making.

Apply to people with disability in all settings (including supported accommodation)

Currently, the Bill only applies to people receiving NDIS supports or services or state disability services provided under the *Disability Services Act 2006* (Qld). However, QAI considers that the Bill should go further and expand the authorisation process to include all people with disability who are subjected to restrictive practices in every setting in which they occur. This should expressly include supported accommodation settings, as discussed above.

Restrictive practices are used in all corners of society and in any context in which a person with disability is perceived to exhibit a 'behaviour of concern' that purportedly poses a threat

¹² See sections 145(1)(c), 146(2)(b) and 158(f)(i)

to the safety of the person or others. This includes in the home, at school, in mental health facilities, in prisons and in residential facilities.

The use of restrictive practices on children with disability in educational settings is a particular concern for 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 such as being locked in cupboards, separated from their peers or physically manhandled. Such practices currently occur at the unfettered discretion of school Principals, without regulation or independent oversight. By the time the Regional Office becomes involved via a complaints process, the student has typically suffered significant harm and been denied access to critical learning opportunities. These practices must therefore carry the same level of independent authorisation that children with disability subjected to restrictive practices in the context of disability service provision, receive.

Expanding the settings in which the authorisation framework applies would better reflect Recommendation 6.35 of the Disability Royal Commission which requires states and territories to ensure appropriate legal frameworks are in place in disability, health, education and justice settings.

Legislate prohibited restrictive practices

QAI understands that there is to be a list of prohibited restrictive practices prescribed by regulation. However, the Explanatory Memorandum does not provide any detail about which restrictive practices are to be prohibited by this regulation.

Restrictive practices constitute some of the most grave human rights violations and our experience tells us that misunderstandings regarding what constitutes a restrictive practice are widespread within the community. Explicitly listing certain practices as prohibited will therefore help to educate the sector and provide a clear expectation regarding what conduct is completely unacceptable, regardless of the circumstances.

The Disability Royal Commission has recommended that “once appropriate legal frameworks are established in line with Recommendation 6.35, prohibitions should be incorporated in

legislation.”¹³ QAI therefore recommends the Committee legislate the prohibition of the following restrictive practices in the Bill (rather than in regulation):

- Containment and seclusion of children under the age of 18
- Prone restraint, supine restraint, pin downs, take down techniques and any technique that interferes with respiration or digestion, pushed a person’s head towards their chest and physical restraints that inflict pain and hyperextension of joints or pressure on joints or chest¹⁴
- The prohibitions contained in the NSW Restrictive Practices Authorisation Policy (v2.0), which includes aversion, over-correction, misuse of medication and denial of key needs
- Constant and intensive supervision or not ensuring an accessible environment¹⁵
- Forcing a person to wear clothing specifically designed to impede behaviours of concern¹⁶
- Employing psychosocial techniques which can impact a person’s exercise and choice and self- determination; i.e. psychosocial restraint, which is ‘the use of inter-personal interactions, which might reasonably be construed by the person to whom they are directed as intimidating or aversive, and/or threats of social or other sanctions which rely upon eliciting fear to moderate a person’s behaviour’¹⁷

¹³ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Final report, Volume 6, Enabling autonomy and access, September 2023, pp 514

¹⁴ As recommended by Griffith University (2020) *Final Report: Independent review of Queensland’s regulatory framework for positive behaviour support and restrictive practices*;
[https://qchub.dsdsatsip.qld.gov.au/app/webroot/js/admin_js/kcfinder/upload/queenslandcommunities/files/PB_SRP_In dependentReview.pdf](https://qchub.dsdsatsip.qld.gov.au/app/webroot/js/admin_js/kcfinder/upload/queenslandcommunities/files/PB_SRP_IndependentReview.pdf); page 8

¹⁵ Active Social Care Limited, *Restrictive Practices* (ND)
<https://activesocialcare.com/handbook/safeguarding-adults/restrictive-practices>

¹⁶ Adelaide Night and Day Family Therapy, *Tied Up in Knots: Systemics, Occupational Therapy and Restrictive Practices* (April 2011)

¹⁷ McVilly, K (2009) *Physical Restraint in Disability Services: Current Practices, Contemporary Concerns and Future Directions*. Melbourne, Victoria: The Office of the Senior Practitioner, Department of Human Services.

- Explicit restrictions on where a person lives, who they live with, how they spend their time, access to personal monies, their right to access the local community, their right to sexual expression, and their right to privacy.¹⁸

These ‘softer’ methods of exerting control can be equally restrictive and destructive of a person’s self- determination and must therefore be prohibited. Further, the Bill should include a provision that explains the list is a non-exhaustive list of practices that are not permitted by law.

Introduce a provider of last resort for the preparation of positive behaviour support plans for containment and seclusion

QAI does not support devolving the responsibility for the development of positive behaviour support plans (**PBSPs**) that include containment and/or seclusion to specialist behaviour support practitioners in the market, even in a phased approach over a 24-month period based on ‘market readiness’ of different regions across Queensland.¹⁹

It is one thing to remove the Government’s statutory monopoly on the preparation of PBSPs for seclusion and containment, but it is another entirely to withdraw as a provider of last resort. While we acknowledge the rationale to remove this function is to allow for greater ‘choice and control’ through the utilisation of the NDIS market, QAI considers that the market will never be ready to solely take on this function owing simply to the inherent nature of a market-based scheme. That is, a scheme whereby participants and service providers are free to make decisions in accordance with their own (sometimes competing) interests.

The grave nature of the limitations imposed by seclusion and containment require a safety net that the free operation of the NDIS market will simply never provide. People with disability subjected to such practices require a level of certainty that they can access PBSPs from a government provider if and when the market cannot provide one. In QAI’s experience,

¹⁸ 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

¹⁹ Explanatory Memorandum, page 2

participants with complex needs (who are more likely to be subjected to restrictive practices) often experience difficulties accessing support as service providers have been known to terminate service agreements when challenges arise. Providers can cease to exist or make decisions based upon revenue and the intensity of resources required to support a particular individual. They can turn clients away and this can leave vulnerable participants with complex needs without PBSPs that regulate the use of restrictive practices used against them. This risk seems like a far stretch from what was originally envisaged by the founders of the NDIS.

Removing the Government's responsibility for developing these PBSPs also mistakenly assumes that participants have sufficient funding in their plan to access them and have ready access to high quality providers, both of which are unfortunately not a reality. Since the introduction of the NDIS, QAI has observed numerous participants having insufficient funding for PBSPs and having to initiate lengthy review processes to obtain increased funding. QAI has also found a marked decline in the quality of PBSPs. There is seemingly a lack of experience among practitioners and a lack of innovation in some PBSPs leading to an increasing use of generic plans that are not tailored to the individual's needs.

This means that people with disability are having their freedoms limited in the absence of evidence-based guidance that will successfully address the behaviour of concern and reduce or eliminate the need for the restrictive practice. Further, the broader remit of the NDIS Restrictive Practice rules has led to an increased demand for PBSPs, yet insufficient registered service providers capable of providing them are available, particularly in rural and remote parts of Queensland. Whilst some of these issues can and theoretically should improve, it will not take away the ability of service providers to terminate agreements and cease supporting participants due to their own prevailing interests.

Though it is suggested the Government will delay absolving this responsibility until such time that the market is 'ready', QAI urges the Queensland government to remain a provider of last resort indefinitely owing to its non-derogable responsibility to protect its most vulnerable citizens from harm. While the NDIS is indeed a market-based scheme, it is not a market of

goods and chattels. It is a market that centers around the lives and rights of people with disability.

A provider of last resort was also recommended by both the Disability Royal Commission (Recommendation 10.10) and the Independent Review of the NDIS (Action 13.4).

Increase accountability of service providers

QAI considers that penalties should be issued to service providers who fail to comply with PBSPs, as well as mandatory training required for service providers who are unable to demonstrate reduced or eliminated restrictive practices over time. This will help to increase the accountability of service providers implementing restrictive practices and would facilitate a greater focus on positive outcomes for people with disability as opposed to processes and compliance alone.

Further, QAI considers that the Bill should include greater restrictions on which staff members at a service provider can implement the authorised restrictive practice. The Senior Practitioner will be able to authorise a service provider to implement a restrictive practice but nothing in the Bill regulates which individual staff members at the service provider can implement the restrictive practice. For example, whether they must be staff with certain qualifications, training or experience. In the current drafting of the Bill, it is feasible that a volunteer at a service provider could find themselves in a situation where they are asked to implement a restrictive practice. This could result in people with disability being subjected to harmful practices applied by unqualified and unsuitable staff members.

Require the Senior Practitioner to work alongside people with lived experience

The team working alongside the Senior Practitioner should also include people with lived experience of disability and restrictive practices.

Conclusion

Regardless of the authorisation model, inadequate funding for positive behaviour support plans and insufficient oversight will continue to constitute significant barriers for Queenslanders with disability seeking to uphold their human rights.

QAI thanks the Community Support and Services Committee for the opportunity to contribute to this inquiry. We are happy to provide further information or clarification of any of the matters raised in this submission upon request.