Australian Federation of Disability Organisations

LEGISLATIVE FRAMEWORK TO REGULATE RESTRICTIVE PRACTICES

NSW Department of Communities and Justice

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Acknowledgements

Australian Federation of Disability Organisations (AFDO) acknowledges Aboriginal and Torres Strait Islander people as the traditional custodians of the land on which we stand. We recognise their continuing connection to land, waters, and community. From our offices in Melbourne, Canberra, Sydney, and Newcastle, we pay our respects to the peoples of the lands on which we operate and to their Elders past, present, and emerging. We also pay our respects to the traditional owners of all lands on which we operate or meet around the country.

AFDO acknowledges people with disability, particularly those individuals that have experienced or are continuing to experience violence, abuse, neglect, or exploitation. We also acknowledge their families, supporters, and representative organisations and express our thanks for the continuing work we all do in their support.

Language used in this document

AFDO uses person-first language, like "people with disability," not identity-first language. This is a deliberate choice made by AFDO. This aligns with the UN Convention on the Rights of Persons with Disabilities. It also matches the language used by all levels of government in Australia. Most other peak bodies in the Australian disability sector also use person-first language.

AFDO chooses to use this language because it puts the person before the disability. It values the individual by seeing them as a person, not a condition.

Consistent with this position, AFDO uses person-first language in this document.

We know many people with disability prefer identity-first language. Disability is a part of their identity. This language shows a connection to the disability community and pride in their disability. It also says society is what disables them.

Views on language use reflect people's identities, experiences of disability, and community attitudes. It is a matter of individual choice and agency. AFDO respects everyone's right to choose how to describe their identity and experiences.

"People with disability," means anyone who is d/Deaf (including people who identify as culturally Deaf), or who has a learning disability, or a sensory, physical, hidden, or mental health condition.

About AFDO

Since 2003, the Australian Federation of Disability Organisations (AFDO) is a specific & cross-disability national peak body and a Disability Representative Organisation (DRO), funded by the Commonwealth government (through the Department of Social Services) to represent and advocate for people with disability and support them to fully take part in Australian life - socially, culturally, politically, and economically. Through our membership (many of whom are national, disability-specific, cross-disability or family led peak bodies)

AFDO is in a position of a national peak of peaks in the disability sector, having a total reach of over four and a half million Australians.

AFDO is also a Disabled Peoples Organisation (DPO), governed, led, and constituted by people with disability. We are within a disability rights movement that places people with disability at the centre of decision-making in all aspects of our lives.

AFDO is a strong, trusted voice for the disability sector. We advocate on national policy, inquiries, and initiatives with governments at all levels in Australia. We work to build a community where people with disability can take part in all aspects of social, economic, political, and cultural life. This means:

- real participation in community life
- building respectful, valued relationships
- social and economic participation, and
- contributing as valued citizens.

Our vision

All people with disability can take part equally in all aspects of social, economic, political, and cultural life.

Our mission

Using the strength of our member organisations to harness the collective power of uniting people with disability to change society into a community where everyone is equal.

Our strategic objectives

- To represent the interests and united voice of our members and people with disability at a national and international level in all relevant forums.
- To build the capacity, profile, reputation, and sustainability of AFDO through the strength of our member organisations.
- To enhance the connection and influence in international disability initiatives by policy, advocacy, and engagement, focused on the Asia Pacific region.

Our members

AFDO's member organisations contribute to the national policy agenda and address issues that impact the lives of people with disability in Australia. We understand that disability specific organisations play a key role in the provision of information and peer support to people with disability and their families. This role keeps them closely connected to their grass roots communities. Each community has its peak organisation that uses its voice to advocate on issues.

Information about AFDO's members can be found on AFDO's website.

1. Acronyms and abbreviations

The following list of terms may assist readers in understanding the terms used in this document.

AFDO	Australian Federation of Disability Organisations
Aged Care Royal Commission	Royal Commission into Aged Care Quality and Safety
APO	Authorised Program Officer
BSP	Behaviour Support Plan
CAT	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[1]
Concluding Observations	2019 Concluding Observations on the combined second and third periodic reports of Australia, by the Committee on the Rights of Persons with Disabilities in 2019[2]
CRPD	United Nations Convention on the Rights of Persons with Disabilities[3], including the Optional Protocol[4]
DDA	Disability Discrimination Act 1992 (Cth)
Department or DCJ	NSW Department of Communities and Justice
Disability Royal Commission or DRC	Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
NDIS	National Disability Insurance Scheme
NDIS Act	National Disability Insurance Scheme Act 2013 (Cth)
NPM	National Preventative Mechanism
OPCAT	Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[5]
PBS	Positive behaviour support
UN	United Nations

2. Executive summary

In summary:

1. **AFDO's strong position is that all Australian jurisdictions must prohibit restrictive practices and end legal authorisation for their use.**
2. **Until that occurs, all Australian jurisdictions must protect all people with disability who are subjected to restrictive practices.**
3. **A focus only on NDIS participants does not fulfill NSW's obligations under the CRPD or CAT (and OPCAT).**
4. **The legislative framework must recognise that restrictive practices are used on people with disability in a variety of settings, and against people with disability who are not NDIS participants. The legislative framework must apply to the use of all restrictive practices against any person with disability in NSW.**
5. **In accordance with Article 15 of the CRPD, the NSW government must establish a nationally consistent legislative and administrative framework for:**
   a. **protection of all people with disability from the use of physical and chemical restraint and seclusion under the guise of "behaviour modification", and**
   b. **elimination of restrictive practices in all settings.**
6. **The NSW legislative framework must be consistent with the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector.**
7. **The NSW legislative framework must also be consistent with, and implement, Draft principles of nationally consistent authorisation of restrictive practices**
8. **In no part of the DRC report did the Royal Commissioners state, or infer, that:**
   a. **the recommended legal frameworks for the use of restrictive practices may or should be limited only to NDIS participants, or**
   b. **the Senior Practitioner would be required to authorise the use of restrictive practices only for the "disability service provision setting".**
9. **With no data to back up the Department's assumption or expectation, there is no justification for limiting the scope of the legislative framework to NDIS participants.**
10. **The role of the Senior Practitioner must not be limited to oversight of the use of restrictive practices in the disability setting (using the language of recommendation 6.35), nor the "disability service provision setting".**
11. **The legislative framework must be consistent with, and must implement in full, recommendation 6.36 of the DRC.**

12. **Conditions required under the Quality-of-Care Principles (amended following the Aged Care Royal Commission) must be satisfied before and during the use of any restrictive practice, including:**
    a. **monitoring the person for signs of distress or harm, side effects, adverse events, and changes in wellbeing, independent functions, or ability to undertake activities of daily living, and**
    b. **to the extent possible, changing the environment to reduce or remove the need for the use of the restrictive practice.**
13. **Consistent with the recommendations of the Aged Care Royal Commission restrictive practices should only be used where the giving of informed consent is given and documented.**
14. **The NSW legislative framework needs to adopt the NDIS definition of restrictive practices, provided the concept of "rights" extends to all rights under international treaties or conventions to which Australia has acceded.**
15. **ADFO urges the Department to enshrine principles for a framework of supported decision making in the proposed legislative framework, to ensure that, where possible, consent to restrictive practices is given by the person concerned, directly or through a framework for supported decision making.**
16. **The powers and functions of a Senior Practitioner must include:**
    a. **promoting the reduction and elimination of the use of restrictive practices**
    b. **protecting and promoting the rights of people with disability subjected to restrictive practices**
    c. **considering applications to use restrictive practices in disability service settings and authorising their use according to procedures consistent with the Draft Principles for Consistent Authorisation**
    d. **receiving complaints about the use of restrictive practices and the quality of behaviour support planning**
    e. **investigating the use of restrictive practices and the quality of behaviour support planning, either in response to complaints or of its own motion, and**
    f. **acting in response to complaints and investigations where appropriate.**

3. Recommendations of the DRC

It is useful to set out in full the text of recommendations 6.35[6] and 6.36[7] of the DRC.

3.1 Recommendation 6.35

Legal frameworks for the authorisation, review and oversight of restrictive practices

(a) States and territories should ensure appropriate legal frameworks are in place in disability, health, education and justice settings, which provide that a person with

disability should not be subjected to restrictive practices, except in accordance with procedures for authorisation, review and oversight established by law.

(b) The legal frameworks should incorporate the following requirements, appropriately adapted to sector-specific contexts. ·

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, and only after other strategies, including supported decision-making, have been explored and applied
- as the least restrictive response possible to ensure the safety of the person with disability or others
- to the extent necessary to reduce the risk of harm and proportionate to the potential negative consequences from the use of restrictive practices
- for the shortest time possible.

Decisions to authorise restrictive practices should be subject to independent review. ·

The use of restrictive practices should be subject to independent oversight and monitoring.

(c) The legal frameworks should set out the powers and functions of a Senior Practitioner for restrictive practices in disability service provision (or equivalent authority). These powers and functions should include:

- promoting the reduction and elimination of the use of restrictive practices
- protecting and promoting the rights of people with disability subjected to restrictive practices
- developing and providing information, education and advice on restrictive practices to people with disability, their families and supporters, and the broader community
- considering applications to use restrictive practices in disability service settings and authorising their use according to procedures consistent with the Draft Principles for Consistent Authorisation
- developing guidelines and standards, and providing expert advice, on restrictive practices and behaviour support planning
- receiving complaints about the use of restrictive practices and the quality of behaviour support planning
- investigating the use of restrictive practices and the quality of behaviour support planning, either in response to complaints or of its own motion
- acting in response to complaints and investigations where appropriate.

3.2 Recommendation 6.36

Immediate action to provide that certain restrictive practices must not be used

State and territory governments should immediately:

(a) Adopt the list of prohibited forms of restrictive practices agreed by the former Disability Reform Council in 2019 and provide that the use of seclusion on children and young people is not permitted in disability service settings.

(b) Provide that the following are not permitted in health and mental health settings:

- using seclusion and restraint as a means to reduce behaviours not associated with immediate risk of harm
- using seclusion and restraint as a form of discipline, punishment or threat
- restrictive practices that involve or include deliberate infliction of pain to secure compliance
- using prone or supine holds, using any restraint intended to restrict or affect respiratory or digestive function, or forcing a person's head down to their chest
- secluding a person who is also mechanically restrained
- secluding a person who is actively self-harming or suicidal
- using metal handcuffs or hard manacles as a form of mechanical restraint (unless under police or other custodial supervision while in the health facility)
- vest restraints for older people
- neck holds
- drugs, or higher doses of drugs, that create continuous sedation to manage behaviour, and
- seclusion of children and young people. ·

(c) Provide that the following are not permitted in education settings:

- the use of restrictive practices:
  - as a form of discipline, punishment or threat
  - as a means of coercion or retaliation
  - in response to property destruction
  - for reasons of convenience
- life threatening physical restraints, including physical restraints that restrict a student's breathing or harm the student by:
  - covering the student's mouth or nose, or in any way restricting breathing
  - taking the student to the ground into the prone or supine position
  - causing hyperextension or hyperflexion of joints
  - applying pressure to the neck, back, chest or joints
  - deliberately applying pain to gain compliance
  - causing the student to fall
  - having a person sit or kneel on the student
- chemical restraints
- mechanical restraints
- clinical holding:
  - as a behaviour support strategy
  - to enforce the compliance of a student in undertaking personal care that is non-urgent and does not present a risk to the student, or
  - to punish a student

- denial of key needs, such as food and water.

4. Settings in which restrictive practices are used

The Department's Consultation Paper notes that restrictive practices are used on people with disability in a variety of settings[8]. Notwithstanding this acknowledgement, the Consultation Paper goes on to say that the proposed legislative framework will only focus on NDIS participants at this time, because

> most people who use disability services and upon whom restrictive practices are used **are expected** to currently be NDIS participants.[9] (our emphasis)

The rationale for focusing on NDIS participants is that this fulfils NSW's obligations for authorising the use of restrictive practices by NDIS providers in relation to NSW participants under the Bilateral Agreement between the Commonwealth and NSW, the NDIS Act, and the NDIS Quality and Safeguarding Framework.

This may be correct – but a focus only on NDIS participants does not fulfill NSW's obligations under the CRPD or CAT (and OPCAT). Australia is a party, and has acceded, to these Conventions and Optional Protocol.

Moreover, the data (such as it is) does not justify any limitation on protection against restrictive practices to only NDIS participants.

4.1 No alignment with community expectations

The use of restrictive practices is normalised and legitimised in law, policy, and practice under the guise of 'behaviour modification' or for 'therapeutic' reasons. Governments tend to focus (as is the case in the Consultation Paper) on service silos in regulating restrictive practices rather than applying a human rights approach. A need for use of restrictive practices is viewed as a service provision issue rather than a violation of human rights that is pervasive across multiple sectors.

The prohibition of torture (under the CRPD, as well as Article 7 of the International Covenant on Civil and Political Rights[10] and the CAT) is one of the most fundamental principles of international human rights law. It is an absolute and universal norm. As such, the ban on torture cannot be derogated under any circumstances whatsoever, not even in a state of war or public emergency. Further, States are not only obligated to refrain from using or condoning torture. They are also required to take positive measures to prevent its occurrence, protect and support victims, investigate any allegations of torture, and prosecute those responsible.

And yet, many restrictive practices in use are a form of torture.

The National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector[11] (National Framework) was endorsed by Commonwealth, State and Territory Disability Ministers at the Disability Reform Council (now the Disability Reform Ministers) meeting on 21 March 2014. Further, on 24 July 2020, the Disability Reform Council agreed to the Draft principles of nationally consistent authorisation of restrictive practices

(Draft Principles) (which was an exhibit to the DRC's Final Report.[12]

The National Framework outlines key principles and core strategies to reduce the use of restrictive practices in the disability service sector. The National Framework also is supposed to enable all Australian Governments to have a consistent approach to reducing and eliminating restrictive practices.

The Draft Principles set a high bar for restrictive practice regulation at a national level, and

> build on the commitment of all governments to national consistency in restrictive practice regulation under the National Framework … and the NDIS Quality and Safeguarding Framework (2016). They also align with Australia's commitments through the UN Convention on the Rights of Persons with Disabilities to uphold the rights of people with disability.[13]

We cannot find any reference to the National Framework or the Draft Principles in the Consultation Paper. For ease of reference, and to assist the Department we set out the National Framework and the Draft Principles in full in the Appendix.

The NSW legislative framework must take into account, and be consistent with, the National Framework and the Draft Principles.

Research undertaken for the Disability Royal Commission in 2023[14] found that:

1. restrictive practices are at odds with international human rights, including the absolute non-derogable prohibition on torture and cruel, inhuman, or degrading treatment or punishment[15], the prohibition of discrimination against people with disability and rights to protection from violence[16] under the CRPD
2. restrictive practices strip people with disability of dignity. They cause trauma, pain, and harm. They generate feelings of violation, abandonment, neglect, and fear. They are disempowering, humiliating, and dehumanising, that cause lifelong trauma and life-altering effects. They are cruel and punishing treatment
3. restrictive practices occur within an ecological system of violence, coercion and control, and
4. current approaches to restrictive practices have limited or inconclusive effects. Positive behaviour support (PBS) has a mixed and inconclusive evidence-base with distinct limitations, that focuses on staff training or on the quality of plans, which prove to be poor quality, and mixed and inconclusive results about the overall effectiveness of PBS.

That research also recommended eight steps to eliminating restrictive practices, directed to society, institutions, relationships, and individuals. Importantly, the first step is to prohibit restrictive practices, and end legal authorisation for their use, which AFDO endorses.

In accordance with Article 15 of the CRPD[17], the NSW government must establish a nationally consistent legislative and administrative framework for:

- protection of all people with disability from the use of physical and chemical restraint and seclusion under the guise of "behaviour modification", and

- elimination of restrictive practices in all settings.

The legislative framework must also support compliance with the rights and obligations under OPCAT[18] by:

- establishing a nationally consistent and disability inclusive approach to the work of National Preventive Mechanisms (NPMs)[19]
- ensuring a disability inclusive approach to the design, implementation, operation, and review of NPMs, and
- compelling all NSW Government agencies to comply with visits from the UN Subcommittee on the Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

We urge the Department to ensure that the legislative framework and the NSW government's approach to restrictive practices is consistent with the National Framework, the obligations under the CRPD and CAT (including OPCAT), and with an approach to reduce and eliminate restrictive practices for all people with disability.

4.2 The Department's expectation is not supported by data

As noted above, the Consultation Paper is based on a fundamental assumption that **most people** who use disability services and upon whom restrictive practices are used **are expected** to currently be NDIS participants.[20]

This statement is not backed up by any data. This assumption is flawed.

The DRC readily acknowledged that

> data collection and reporting on the use of restrictive practices towards people with disability in Australia are poor. No robust datasets are regularly published, either at the national or state and territory level. This means the use of restrictive practices cannot be properly assessed, monitored over time or compared across settings or jurisdictions. There are gaps in data about the types of restrictive practices used and characteristics of people with disability subjected to them.[21]

It is wrong for the Department (if this is what has happened) to assume that because the DRC considered data from NDIS provider monthly reports to the NDIS Commission on the use of authorised restrictive practices and NDIS Commission published data on unauthorised restrictive practices (collected as a category of reportable incidents) that the DRC was only concerned with restrictive practices against NDIS participants, or that only NDIS participants are, or are likely, to be subjected to authorised and unauthorised restrictive practices. As the DRC itself noted, there is no robust data to demonstrate the use of unauthorised restrictive practices over time and, for these reasons, "caution must be used when drawing conclusions from the … data".[22]

The DRC also sought to interrogate data in respect of the use of restrictive practices in settings other than NDIS service provision. However, the DRC considered it was unable to rely on the scant data available or provided to quantify the extent to which restrictive practices

are used against people with disability in health, education, and other settings. This was due to apparent underreporting, small sample sizes and incomplete data provided by states and territories.[23]

It is also important that we draw to the attention of the Department data on the use of restrictive practices that was carefully considered by the ALRC in 2014[24].

The ALRC concluded that persons with disability who display 'challenging behaviour', or 'behaviours of concern' may be subjected to restrictive practices or medical intervention in a variety of contexts, including supported accommodation and group homes; residential aged care facilities; rehabilitation centres; mental health facilities; hospitals; prisons; and schools.[25]

The ALRC considered "limited available data" from the Victorian Office of the Senior Practitioner (which accorded with the international research) that an estimated 10–15% of persons with disability will show 'behaviours of concern' and between 44–80% of them will be administered a form of chemical restraint in response to the behaviour.[26]

The Department of Health and Ageing told the Senate Inquiry into dementia that the use of drugs in dementia is higher than would be expected on clinical grounds alone:

> In February 2013 [the drug utilisation subcommittee] found that there is a high and inappropriate utilisation of antipsychotics in the elderly, especially in the case of two drugs: quetiapine and olanzapine, which are prescribed at a rate inconsistent with the age-specific prevalence of bipolar disease.[27]

Further, between 50–60% of people presenting challenging behavior in the United Kingdom were subjected to physical restraint;[28] with those with multiple impairments and complex support needs may experience much higher levels of restrictive practices.

With no data to back up the Department's assumption or expectation, there is no justification for limiting the scope of the legislative framework to NDIS participants.

AFDO urges the Department to ensure the legislative framework recognises that restrictive practices are used on people with disability in a variety of settings, and against people with disability who are not NDIS participants. The legislative framework must apply to the use of all restrictive practices against any person with disability in NSW.

5. Governing requirements

Proposal 1:

Legislation should provide that the use of restrictive practices on NDIS participants in the disability service provision, health, education and justice settings should be governed by the principles recommended by DRC Recommendation 6.35(b).

Proposal 2:

The legislation should require government agencies in the health, education and justice settings to provide an annual report to the Senior Practitioner on their, and their contractors', compliance with the principles.

5.1 Do you support legislation requiring that restrictive practices on NDIS participants in the disability service provision, health, education and justice settings should be governed by the principles recommended by DRC Recommendation 6.35(b)?

AFDO fully supports a legislative framework that:

(a) regulates (with a view to minimising as far as possible, and with a goal of eliminating) the use of restrictive practices on **all people with disability** in **disability**, health, education, and justice settings, and

(b) prevents a person with disability from being subjected to restrictive practices, except in accordance with procedures for consent, authorisation, review, and oversight established by law.

The Department's Consultation Paper proposes the proposed legislative framework (and the requirements[29] recommended by the DRC) would apply to the provision of NDIS funded services by NDIS providers, as well as the use of restrictive practices on NDIS participants by government agencies and their contractors in the health, education, and justice settings[30].

The Consultation Paper also states the Senior Practitioner

> would have visibility over the implementation of the principles through its regulation of NDIS providers and through agencies reporting annually on their and their contractors' compliance. However**, consistently with recommendation 6.35** of the DRC, it is proposed that the Senior Practitioner would be required to authorise the use of restrictive practices **only for the disability service provision setting**.[31] (our emphasis)

AFDO is very concerned that the Department misunderstands, or has misconstrued, the clear wording of recommendation 6.35, and the DRC's conclusions drawn in volume 6 of the DRC's Final Report.

Firstly, contrary to what the Department suggests in the Consultation Paper[32], recommendation 6.35 does **not recommend** that "states and territories ensure appropriate legal frameworks are in place to regulate restrictive practices applied to a person with disability in **disability service provision**" settings. Recommendation 6.35 recommends appropriate legal frameworks are in place in "disability" settings.[33] A "disability setting" is not the same as, and not so limited as the definition[34] of, a "disability service provision" setting.

In addition, the DRC makes it very clear the requirements it has set out for legal frameworks for the use of restricted practices against people with disability "are intended to apply generally"[35], and that legal framework must apply to any person or entity from or within the disability, health, education, and justice settings with power to authorise the use of or use restrictive practices on people with disability[36].

Further, the

> use of restrictive practices should be independently overseen and

> monitored and authorisation decisions should be subject to independent review. The legal framework ideally should provide remedies for the unlawful use of restrictive practices.[37]

This does not qualify or limit the role of oversight and monitoring of the use of restrictive practices.

In no part of the report did the Royal Commissioners state, or infer, that:

(a) the recommended legal frameworks for the use of restrictive practices may or should be limited only to NDIS participants, or

(b) the Senior Practitioner would be required to authorise the use of restrictive practices only for the disability service provision setting, nor only for the disability setting (to use the wording used by the DRC in recommendation 6.35.

5.2 Should a legislative framework prohibit any practices? If so, which practices and in which settings?

The legislative framework must be consistent with, and must implement in full, recommendation 6.36 of the DRC[38].

Further, conditions required under the Quality-of-Care Principles[39] (amended following the Aged Care Royal Commission) must be satisfied before and during the use of any restrictive practice outside of emergency situations, including:

1. monitoring the person for signs of distress or harm, side effects, adverse events, and changes in wellbeing, independent functions, or ability to undertake activities of daily living,[40] and
2. to the extent possible, changing the environment to reduce or remove the need for the use of the restrictive practice.[41]

Consistent with the recommendations of the Aged Care Royal Commission restrictive practices should only be used where the giving of informed consent is documented.[42].

6. Definition of restrictive practices

Proposal 3:

The NDIS definitions of restrictive practices should be adopted for the NSW legislative framework for restrictive practices.

Proposal 4:

The Senior Practitioner should have the power to issue guidelines that clarify how the definitions apply in different situations.

6.1 Do you agree that the framework should use the NDIS definitions of restrictive practices?

Yes, provided that the concept of “rights” extends to all rights under international treaties or conventions to which Australia has acceded.

6.2 Do you agree the Senior Practitioner should have the power to issue guidelines that clarify how the definitions apply in different situations?

Yes, subject to that power, and the exercise of that power, being subject to administrative and judicial review.

7. Framework for supported decision making

In 2014, the Australian Law Reform Commission undertook a comprehensive review of equality, capacity, and disability in Commonwealth laws. The ALRC's final report[43] made 55 recommendations for reform that will better provide people with disability equal recognition before the law - in particular, in relation to the right to make decisions that affect their lives and to have those decisions respected.

National Decision-Making Principles[44], developed by the ALRC to guide reform at a national level, are at the heart of the recommended reforms that shift the focus away from 'best interests' decision-making to a focus on 'wills, preferences and rights'.

A key recommendation was to establish a new Commonwealth decision-making model that will encourage the adoption of supported decision-making at a national level. The recommended model would introduce mechanisms for the appointment of 'supporters' for adults who may require decision-making support, and provisions relating to 'representatives' to address circumstances in which a person may desire, or require, someone else to make decisions for them.

In 2023, La Trobe University's Living with Disability Research Centre published a report for the DRC: Diversity, dignity, equity and best practice: a framework for supported decision-making[45]. This report includes nine best practice principles and eight best practice elements that should underpin a national supported decision-making framework for Australia.

In the absence of any steps by the Commonwealth to implement these principles at a national level, ADFO urges the Department to enshrine these principles in the proposed legislative framework, to ensure that, where possible, consent to restrictive practices is given by the person concerned, directly or through a framework for supported decision making. This must have regard to:

- the model framework recommended by AHRC, and
- the best practice principles and best practice elements identified in La Trobe University's Living with Disability Research Centre report Diversity, dignity, equity and best practice: a framework for supported decision-making.

8. Informed consent

Informed consent is an essential requirement for the use of any restrictive practice. It must also be an essential requirement for immunity from civil or criminal liability for the use of a restrictive practice.

There is no guidance in the proposed legislative framework as to what constitutes "informed

consent". There is no requirement for the information necessary for any consent to be "informed" to be provided in a manner that is accessible for the individual, or in a way the individual has requested and understands. There is no requirement for the necessary informed consent to be sought, and given, prior to the use of the restrictive practice.

Further, it is important to clearly set the required capacity standard, and the point in time at which capacity is assessed.

Is the capacity standard required:

(a) testamentary capacity

(b) the ability to make reasonable judgments or understand the nature and effect of a document[46]

(c) the individual can manage his or her person[47],

(d) understanding the nature and significance of the restrictive practice on the individual's rights or freedom of movement?

Any assessment of "capacity" must only be judged at the time at which consent is needed. The assessment must not be 'status' based, nor based on a medical model. The existence of a "cognitive impairment" must not be used to automatically permit a limitation on the exercise of agency by the individual, nor automatically be considered as a limitation on the recognition of legal capacity.

When assessing "capacity", consideration must be given to any decision-making assistance and supports that are available or should reasonably be made available in determining whether the individual has the necessary capacity to provide informed consent. (See **section 7** above).

Further, to allow another person to consent to use of restrictive practices on an individual, as proposed, it is essential that (as the Senate Standing Committee for the Scrutiny of Bills has noted in connection with the restrictive practices provisions under the Commonwealth Aged Care Act 2024)

> at a minimum, guidance should (be) included on the face of the bill as to the considerations and safeguards that apply when identifying persons and bodies who may consent to restrictive practices in recognition of the significant trespass on rights and liberties that these practices represent.[48]

The legislative framework must also require the person who uses restrictive practices to make, and keep, any record of:

1. the restrictive practice, and specific details of its use
2. where the individual does not have capacity to consent, the identity of the person who gave informed consent, their relationship to the individual and their contact details
3. the information provided to the person providing informed consent that establishes the person was properly informed before consent was given

4. any capacity assessment made of the individual concerned, including the timing and all other circumstances relevant to that assessment
5. details of any decision-making assistance and supports available to the individual concerned at the time of consent, or any capacity assessment, and
6. the terms of the consent given, and the place, date, and time at which consent was given.

All these records must be created, kept by the person who is seeking consent, or who uses a restricted practice and included in the personal information of the individual on whom the restricted practice was used, for at least seven years after the death of the individual concerned.

9. Discretion and emergency use

Proposal 6:

The Senior Practitioner and APO should have a discretion to determine the duration of an authorisation, up to 12 months.

Proposal 7:

There should be an emergency use process for restrictive practices before a BSP has been prepared and authorisation given, which should replace the interim authorisation process.

Proposal 8:

The Senior Practitioner should have the power to cancel an authorisation of restrictive practices where:

- the Senior Practitioner has determined there is no longer a need for the restrictive practice
- the Senior Practitioner requests evidence to demonstrate the restrictive practice is still needed and the provider fails to provide sufficient evidence
- the authorisation was obtained by materially incorrect or misleading information or by mistake
- the relevant provider has contravened a condition of the authorisation, or
- the relevant service provider has contravened a provision of the legislation

9.1 Do you support the proposed duration of authorisation and emergency use proposals for restrictive practices?

If there is to be a process for “emergency use” of restrictive practices, there must be clear guidance in the legislative framework as to what constitutes an emergency, and a prohibition on a determination of an emergency after the use of a restrictive practice has been applied to an individual. There must also be clear guidance as to who determines that an emergency is occurring or has occurred. There can be no justification in any emergency for removing the requirement that a restrictive practice must be used:

(a) as a last resort, or

(b) in the least restrictive form and for the shortest time.

10. Senior Practitioner powers and functions

Proposal 12:

The Senior Practitioner should have the following functions:

- developing and providing information, education, and advice on restrictive practices to people with disability, their families and supporters, and the broader community
- developing guidelines and standards, and providing expert advice, on restrictive practices and behaviour support planning.

The powers and functions of a Senior Practitioner must include:

- promoting the reduction and elimination of the use of restrictive practices
- protecting and promoting the rights of people with disability subjected to restrictive practices
- developing and providing information, education, and advice on restrictive practices to people with disability, their families and supporters, and the broader community
- considering applications to use restrictive practices in disability service settings and authorising their use according to procedures consistent with the Draft Principles for Consistent Authorisation[49]
- developing guidelines and standards, and providing expert advice, on restrictive practices and behaviour support planning
- receiving complaints about the use of restrictive practices and the quality of behaviour support planning
- investigating the use of restrictive practices and the quality of behaviour support planning, either in response to complaints or of its own motion, and
- acting in response to complaints and investigations where appropriate.[50]

The Senior Practitioner should be the primary agent responsible for NSW's efforts to reduce and eliminate the use of restrictive practices in disability service settings. The Senior Practitioner should pursue these outcomes through raising awareness about restrictive practices and behaviour support planning among people with disability, their families, friends and supporters, disability service providers and the broader community.

The role should also support disability service providers by developing guidelines and standards and providing expert advice on the use of restrictive practices and behaviour support planning.

Appendix

National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Services Sector

High-level Definitions

A nationally agreed set of high-level definitions will guide legislation and policy development, and will facilitate greater inter-jurisdictional collaboration. The following definitions will be used by jurisdictions for implementation, reporting and evaluating progress against the National Framework.

The definitions are intended as high-level definitions only, under which restrictive practices should be categorised. It is anticipated that definitions in the National Framework will guide and support the development of detailed operational guidelines and mechanisms as appropriate in jurisdictional settings.

People With Disability

Within the National Framework, "people with disability" refers to persons in receipt of disability support services under the National Disability Agreement and the NDIS.

Individualised/behaviour support

The National Framework articulates principles and strategies for maximising individualised behaviour support for people with disability, with the overall objective of reducing the occurrence and impact of challenging behaviour and the use of restrictive practices. This may include the provision of positive behaviour support and development of an individual/behaviour support plan.

Positive Behaviour Support is the term used to describe the integration of the contemporary ideology of disability service provision with the clinical framework of applied behaviour analysis. Positive Behaviour Supports are supported by evidence encompassing strategies and methods that aim to increase the person's quality of life and reduce challenging behaviour (*Source Note: Carr et al, 2002; Singer & Wang, 2009*).

An individual/behaviour support plan is a plan developed for a person with disability which specifies a range of strategies to be used in supporting the person's behaviour, including proactive strategies to build on the person's strengths and increase their life skills.

Restrictive practice

A "restrictive practice" is defined as any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability, with the primary purpose of protecting the person or others from harm.

Seclusion

"Seclusion" means the sole confinement of a person with disability in a room or physical space at any hour of the day or night where voluntary exit is prevented, implied, or not facilitated.

Chemical restraint

A "chemical restraint" means the use of medication or chemical substance for the primary purpose of influencing a person's behaviour or movement. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment, of

a diagnosed mental disorder, a physical illness or physical condition.

Mechanical restraint

A "mechanical restraint" means the use of a device[1] to prevent, restrict or subdue a person's movement for the primary purpose of influencing a person's behaviour but does not include the use of devices for therapeutic or non-behavioural purposes. For example, purposes may include the use of a device to assist a person with functional activities, as part of occupational therapy, or to allow for safe transportation.

Physical restraint

A "physical restraint" means the sustained or prolonged2 use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing a person's behaviour. Physical restraint is distinct from the use of a hands-on technique in a reflexive3 way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person.

Additional restrictive practices

This Framework aims to reduce the use of restrictive practices that comply with applicable jurisdictional regulatory, policy and work practice requirements.

Some jurisdictions may have arrangements that authorise the use of additional restrictive practices to those defined above, including those broadly termed as:

- psycho-social restraints, usually involving the use of 'power-control' strategies;
- environmental restraints, which restrict a person's free access to all parts of their environment; and
- consequence driven practices, usually involving the withdrawal of activities or items.

Qualification

Existing Commonwealth, State and Territory legislation sets out their own respective practices that are unlawful and constitute criminal offences and civil wrongs that may lead to legal action, including assault, abuse, neglect or wrongful imprisonment. The National Framework intends to work within existing legislative arrangements, to set out minimum requirements in relation to restrictive practices and guide jurisdictions' individual arrangements.

High-level Guiding Principles

The following high-level guiding principles should underpin planning, implementation and evaluation of the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector.

[1] A device may include any mechanical material, appliance or equipment.
[2] For example, a physical force or action lasting longer than approximately 30 seconds, that is not a reflexive manual restraint (McVilly, 2008).
[3] For example, momentary contact to guide or redirect a person, lasting for no more than approximately 30 seconds (McVilly, 2008).

1. Human rights:
   a. Full and equal enjoyment of all human rights and fundamental freedoms by people with disability without discrimination of any kind, as outlined in the United Nations Convention on Rights of Persons with Disabilities[4]. People with disability have equal rights to those of all members of society, including but not limited to the right to:
      i. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons (Article 3);
      ii. Equality before the law and to equal protection under the law, without discrimination (Article 5);
      iii. Liberty and security of the person (Article 14);
      iv. Freedom from torture or cruel, inhuman or degrading treatment or punishment (Article 15);
      v. Freedom from exploitation, violence and abuse (Article 16);
      vi. Respect for his or her physical and mental integrity on an equal basis with others (Article 17);
      vii. Personal mobility with the greatest possible independence (Article 20);
      viii. Freedom of expression and opinion and access to information (Article 21);
      ix. The highest attainable standard of health without discrimination on the basis of disability (Article 25);
      x. Attain and maintain maximum independence, full physical, mental social and vocational ability, and full inclusion and participation in all aspects of life (Article 26); and
      xi. An adequate standard of living for themselves and their families, and to social protection without discrimination on the basis of disability (Article 28).
   b. Recognising an individual's rights is paramount. Restrictive practices should occur only in very limited and specific circumstances, as a last resort and utilising the least restrictive practice and for the shortest period of time possible under the circumstances. Restrictive practices should only be used where they are proportionate and justified in order to protect the rights or safety of the person or others.

2. Person-centred focus:
   a. People with disability (with the support of their guardians or advocates where required) are the natural authorities for their own lives and processes that recognise this authority in decision making, choice and control should guide the design and provision of services.
   b. Approaches, including behaviour support planning, will be individualised and involve personalised supports that are informed by evidence-based best practices.
   c. Disability service providers should seek to understand the nature and function of a person's behaviour and to respond appropriately to that behaviour, ensuring the use of restrictive practices in very limited and specific circumstances and only as a last resort.

[4] Article 1, United Nations Convention on the Rights of Persons with Disabilities

d. An emphasis on prevention including proactive skills building and environmental design to produce desirable behaviour change.
e. Provision of decision support to assist people with disability and their guardians or advocates to identify needs and goals, plan their service requirements, access services, and maximise participation in decision making.
f. Maximum respect for a person's autonomy, including:
    i. Recognising the presumption of capacity for decision making;
    ii. Seeking a person's consent and participation in decision making (with support if necessary) prior to making a substitute decision on their behalf; and
    iii. Engaging the appropriate decision maker and seeking consent where appropriate, where a decision must be made on behalf of a person.
g. People with disability and their guardians or advocates are informed restrictive practices may be used in the service(s) that they access, noting that restrictive practices are implemented on an individual basis.

3. A national approach:
a. The principles of the National Framework should apply across Australia to ensure people have access to the same protections, in regard to restrictive practices, regardless of where they live.
b. All jurisdictions and levels of government should ensure that disability services meet agreed standards focusing on protecting and promoting the human rights of people with disability.
c. Disability service providers and their staff understand and comply with relevant Commonwealth, State and/or Territory legislative and policy frameworks around use and reduction of restrictive practices.
d. An integrated response between all governments to practices, outcomes and reporting in order to build a representative picture of the use and reduction in restrictive practices, without changing core governance arrangements.

4. Delivering quality outcomes and safe work places:
a. Policies, procedures and tools should protect the rights of people with disability, focusing on improving clients' quality of life, and reducing and monitoring the use of restrictive practices.
b. Disability service providers should ensure that people with disability have protection against inhuman or degrading treatment and attention is provided to personal dignity, privacy and self-respect as well as individual needs.
c. Staff have the right to work in a safe environment and disability service providers may have legal obligations with respect to the observance of work health and safety.
d. Review mechanisms are developed, maintained and utilised for: client and staff de-briefing, review of restrictive practices used (incident reporting), assessment of appropriateness and alternatives, and for aggregated reporting on an organisational and service provider basis.

5. Accountability through documentation, benchmarking and evaluation – working towards transparent and consistent reporting:
a. Formal assessment, planning, approval and review processes, that are based on valid and evidence-based risk assessments undertaken by appropriate

professionals, should be required to authorise and monitor the use of restrictive practices.

b. Transparent reporting mechanisms to:
   i. Ensure accountability and that the person with disability and their guardian or advocate are involved as far as possible; and
   ii. Detail independent monitoring, and access to independent processes for complaints, or review and appeal of decisions to use restrictive practices; and
   iii. Allow for the analysis of trends to evaluate the effectiveness of the strategies and recognise where there may be an increased reliance on the use of restrictive practices.

c. Measure success through a national picture (or stocktake) of the use and reduction of restrictive practices.

6. Collaboration between service providers:
   a. A commitment to developing and maintaining stronger relationships across the health, allied health, aged care and disability sectors, including between physicians, nurses, mental and other health professionals, and disability services staff to ensure a multidisciplinary approach to the monitoring, use and reduction of restrictive practices.
   b. Collaborative approaches across sectors for client assessment, planning and review should be encouraged by all service providers involved with implementing a person's individual/behaviour support plan. Collaboration should enable a solid basis for individualised, person-centred approaches aimed at reducing the use of restrictive practices.

7. Raising awareness, providing education and facilitating accessible information about restrictive practices:
   a. A commitment to raising awareness of issues relating to the use of restrictive practices, including amongst people with disability and their guardians or advocates as key stakeholders in decision making, and in the implementation of behaviour support strategies and plans.
   b. People with disability and their guardians or advocates should be made aware of the relevant rights within jurisdictions to complain or seek a review of the use of restrictive practices and to participate fully in formal complaint resolution or review processes.
   c. A commitment to building capacity and reducing barriers amongst people with disability and their guardians or advocates to utilise complaint or review mechanisms about restrictive practices.
   d. People with disability and their guardians or advocates are informed that restrictive practices may be used in the service(s) that they access, noting that restrictive practices are implemented on an individual basis.

Core Strategies for a National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector

Jurisdictions agree that by 2018, all disability service providers for which they or the NDIA have funding responsibilities should implement the following set of key core strategies to reduce the use of restrictive practices in disability services.

A comprehensive review of the research literature found evidence for six core strategies for

reducing the use of restrictive practise (*Source Note: Rimland, 2011*). The six core strategies are:

1. Person-centred focus

Including the perspectives and experiences of people with disability and their families, carers, guardians and advocates during restrictive practice incident de-briefing, individualised behaviour support planning, staff education and training, and policy and practice development is a key element of restraint minimisation across sectors *(Source Note: Azeem et al., 2011)*.

Key implementation areas are:

a. Development and regular review of individual/behaviour support plans (including strategies for de-escalation and ensuring the safety of the person, staff and others) that are based on valid and evidence-based risk assessments, in conjunction with people with disability, and their guardians or advocates where appropriate, as active participants in decisions about their lives, support and care.
b. Development and use of appropriate individualised behavioural and environmental risk assessment tools by disability service providers, which are in line with human rights and person-centred approaches.
c. Development of individualised and evidence-based practices such as teaching the use of replacement skills (skills the person can use to replace the challenging behaviours), based on the principles of positive behaviour support.
d. Availability of tools to assist people with disability and their guardians or advocates (where appropriate) to participate in decision making.

2. Leadership towards organisational change

Leaders play an important role in facilitating processes, structures and resources for supporting change. While acknowledging that whole of organisation approaches are required, the senior management of disability services must create a goal of reducing restrictive practices and make it a high priority. Leaders must also support their staff through workforce development opportunities, the development of restraint and seclusion reduction tools, and implementation of rigorous evidence-based debriefing techniques to move away from the use of restrictive practices *(Source Note: Williams and Grossett, 2011)*.

Key implementation areas are:

a. Leaders at all levels, across government and the non-government sector, commit to implement reduction in the use of restrictive practices.
b. Governments provide strategic direction to disability service providers.
c. Disability service providers form relevant governance structures and groups to provide organisational support mechanisms aimed at reducing restrictive practices.
d. Clear and transparent mechanisms for disability representatives and stakeholders to inform policy makers on practices and guidelines.

3. Use of data to inform practice

Mechanisms to trigger periodic review of restraint authorisations, client assessments and individual/behaviour support plans are necessary to continuously assess the necessity of restrictive practices and possible alternative restrictive practices. Data is also important to determine what factors are effective in reducing or eliminating the use of restrictive practices. *(Source Note: Webber et al., 2012)*.

Key implementation areas are:

a. Collection of data at a service unit and/or organisational level to inform and improve future practice and to contribute to national data collection.

b. Identification of baseline data to be collected, ability to set improvement and performance targets and to evidence how this will be used to reduce reliance on restrictive practices.
c. Development and maintenance of an auditing tool to evaluate the use of restrictive practices, including the frequency with which they are used. The tool should have capacity to feed back into the support of people with disability, including into risk assessments and service review – preferably integrated with disability service provider staffing and management systems.
d. Collection of, and measuring outcomes through, feedback from people with disability and staff about their experiences with restrictive practices within disability services.
e. Make use of data on formal complaints or reviews about the use of restrictive practices in disability services, made through existing complaint or review mechanisms, such as an Ombudsman or Tribunal, or through new mechanisms that may become available through the NDIS, where appropriate.

4. Workforce development

There is good evidence to show that disability support staff who understand positive behaviour support, functional behaviour assessment as well as a focus on skills for trauma informed care, risk assessment, de-escalation, and restrictive practice alternatives are able to provide good support and reduce their use of restrictive practices to people who have complex needs.

Key implementation areas are:
a. Promote the use of interdisciplinary approaches toward assessment, intervention and individual/behaviour support plans.
b. Competency assessment, individually tailored training and education for staff and managers, including on: restraint reduction, valid and evidence-based risk assessment, positive behaviour support and relevant Commonwealth, State and Territory legislative frameworks including human rights legislation in the Disability Discrimination Act 1992 (Cth) and equivalents and international human rights treaties.
c. Disability service providers implement guidelines, processes and protocols for staff and managers, that are informed by evidence-based best practice.
d. Debriefing and support – continuous improvement for staff at all levels.

5. Use within disability services of restraint and seclusion reduction tools

Restrictive practices reduction tools need to be based on core assessment and prevention approaches, the results of which need to be integrated into each individual's support plan *(Source Note: Huckshorn, 2005)*.

These approaches would include:
- Evidence-based assessment tools which screen for increased risk of violence, physical and emotional issues which counter-indicate restrictive practices.
- Emergency management plans.
- Changes to the therapeutic environment.
- Meaningful activities aimed at lifestyle improvement and increased engagement.

Key implementation areas are:
a. Practice guides and reference material on reduction tools and processes for staff and managers.
b. Integration with service provider staffing and management systems.

6. Debriefing and practice review

Disability service providers should undertake regular review processes of their use of restrictive practices in order to identify areas for practice and systemic improvement.

Following the unanticipated or emergency use of a restrictive practice, an immediate "post event" debriefing should be completed on site led by the appropriate senior staff member on duty. The goal of this immediate debriefing is to ensure that everyone is safe, that satisfactory information is available to inform the later structured debriefing process and that the person subject to the restraint is safe and being appropriately monitored. Formal debriefing should occur within days after the event and include all involved, the treatment team and relevant administrative staff. (*Source Note: Huckshorn, 2005*).

People with disability and their guardians or advocates should be involved in debriefing and review processes to ensure their perspectives and experiences are understood.

Key implementation areas are:

a. Practice guides and reference material for staff at all levels.

Measuring Performance/ Effectiveness

Jurisdictional reporting on progress of the implementation of the National Framework will occur on a biennial basis. Monitoring of the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector will provide enhanced accountability, public transparency and a national picture and measurement of effectiveness aimed at improving practice. By 2018, all jurisdictions or the NDIA where it is the funder of a support that involves restrictive practices, are encouraged to implement a data monitoring system that integrates with existing service delivery management systems.

Work will initially focus on seeking agreement to achieve standardised data collection and reporting (including for voluntary reporting where commitments occur) in order to establish benchmarks and performance indicators that measure effectiveness in reducing restrictive practices over time. Milestones will be developed which take an incremental approach toward reaching data reporting capacity on the use of restrictive practices by disability services.

Future opportunities may arise through the evaluation of the National Framework, for expansion of these six core strategies to be integrated into other mainstream service sectors that support people with disability such as in health, education and criminal justice.

DRAFT Principles for Nationally Consistent Authorisation of Restrictive Practices

1. Authorisation arrangements for the use of restrictive practices on people with disability are provided for in legislation and support the reduction and elimination of restrictive practices as agreed by all Australian Governments
2. Authorisation arrangements, and the systems surrounding them, should be designed to support positive outcomes for people with disability who are subject to restrictive practices with the objective or reducing and ultimately eliminating those practices
3. People with disability who are subject to restrictive practices have the same protections and rights to be free from abuse, neglect, and exploitation regardless of their disability, age and where they live
4. People with disability and their support networks are actively supported in the decision-making process about the use of restrictive practices, and alternative practices that may improve outcomes for the person with disability through the reduction of their use
5. Authorisation decisions made under state and territory regulatory frameworks are informed by independent advice from experts with relevant training, skills and experience in positive behaviour support and restrictive practices
6. Authorisation frameworks should ensure that any conflicts of interest between key parties involved in decision making on the use of restrictive practices, being people with disability, their support networks, and service providers are effectively mitigated
7. Authorisation arrangements promote independence and dignity of risk while also considering the interests and protection of rights of the person with disability
8. Decisions made on the use of restrictive practices are able to be reviewed if required through relevant state or territory mechanisms
9. Authorisation arrangements are streamlined and take into account the impact of administrative burden on providers enabling resources to be focused on quality service delivery to people with disability
10. Commonwealth state and territory governments will continue to work together to apply these principles in practice, using the NDIS governance arrangements to monitor progress in achieving national consistency.

Endnotes

[1] Retrieved from https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-against-torture-and-other-cruel-inhuman-or-degrading accessed 20 February 2025.

[2] Retrieved from https://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhsnzSGolKOaUX8SsM2PfxU7sdcbNJQCwlRF9xTca9TaCwjm5OInhspoVv2oxnsujKTRETaVWFXhEZM%2F0OdVJz1UEyF5IeK6Ycmqrn8yzTHQCn accessed 20 February 2025.

[3] Retrieved from https://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf accessed 20 February 2025.

[4] Retrieved from https://www.ohchr.org/en/instruments-mechanisms/instruments/optional-protocol-convention-rights-persons-disabilities accessed 20 February 2025.

[5] Retrieved from https://www.ohchr.org/en/instruments-mechanisms/instruments/optional-protocol-convention-against-torture-and-other-cruel accessed 20 February 2025.

[6] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Final Report - Volume 6, Enabling autonomy and access, Commonwealth of Australia, 29 September 2023, pp 34-35, retrieved from https://disability.royalcommission.gov.au/publications/final-report-volume-6-enabling-autonomy-and-access accessed 19 February 2025.

[7] ibid. pp 35-36.

[8] NSW Department of Communities and Justice, Consultation paper A legislative framework to regulate restrictive practices, State of New South Wales, December 2024, p.15 retrieved from https://www.haveyoursay.nsw.gov.au/rpl-framework accessed 19 February 2025.

[9] ibid.

[10] Retrieved from https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights accessed 20 February 2025.

[11] https://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/national-framework-for-reducing-and-eliminating-the-use-of-restrictive-practices-in-the-disability-service-sector

[12] EXHIBIT 6-25.04 - CTD.7200.0002.0844 - Draft principles of nationally consistent authorisation of restrictive practices, retrieved from EXHIBIT 6-25.04 - CTD.7200.0002.0844 - Draft principles of nationally consistent authorisation of restrictive practices | Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability accessed 21 February 2025.

[13] ibid.

[14] Spivakovsky, C., Steele, L., & Wadiwel, D. (2023). Restrictive Practices: A Pathway to Elimination. Australia: Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, accessed 17 October 2024, retrieved from https://disability.royalcommission.gov.au/publications/restrictive-practices-pathway-elimination

[15] Note 3, article 15.

[16] ibid., article 16.

[17] Note 15.

[18] Note 5.

[19] Retrieved from https://www.ohchr.org/en/treaty-bodies/spt/national-preventive-mechanisms accessed 20 February 2025.

[20] Note 9.

[21] Note 6, p.554.

[22] ibid. p. 557.

[23] In relation to education settings for example, ibid., p. 564.

[24] Australian Law Reform Commission, Equality, Capacity and Disability in Commonwealth Laws, ALRC Report 124, Commonwealth of Australia, 18 September 2014, retrieved from https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-alrc-report-124/8-restrictive-practices-2/the-use-of-restrictive-practices-in-australia/ accessed 21 February 2025.

[25] ibid. paragraph 8.6.

[26] ibid. paragraph 8.7, citing Eric Emerson, Challenging Behaviour: Analysis and Intervention in People with Severe Intellectual Disabilities (Cambridge University Press, 2001); Kathy Lowe et al, 'The Management and Treatment of Challenging Behaviours' (2005) 10 Tizard Learning Disability Review 34, cited in 'Chemical Restraint: What Every Disability Support Worker Needs to Know' (Office of the Senior Practitioner, Victoria, August 2008) 1. Victorian figures on behaviour support plans cited in Paul Ramcharan et al, 'Experiences of Restrictive Practices: A View from People with Disabilities and Family Carers' (Research Report, Office of the Senior Practitioner, 2009) 12.

[27] Commonwealth, Committee Hansard, Senate, 17 July 2013, 40–41 (Ms Adriana Platona).

[28] Eric Emerson, 'The Prevalence of Use of Reactive Management Strategies in Community-Based Services in the UK' in David Allen (ed), Ethical Approaches to Physical Interventions: Responding to Challenging Behaviour in People with Intellectual Disabilities (BILD, 2003).

[29] The consultation paper describes and refers to the requirements set out by the DRC in recommendation 6.35 as "principles". To the extent to which there is a difference between "principles" and "requirements" (and we think the distinction is considerable, and

significant), the legislative framework must make it clear that the matters recommended by the DRC in paragraph (b) are essential requirements.

[30] Note 8, p.10.

[31] ibid.

[32] ibid. p. 14.

[33] Note 6.

[34] Note 8, p15.

[35] Note 6, p. 577.

[36] ibid.

[37] ibid.

[38] Note 2.

[39] Quality of Care Amendment (Restrictive Practices) Principles 2022 (Cth).

[40] s 15GA(a)(i), (ii), (iv), (v).

[41] s 15GA(d).

[42] Royal Commission into Aged Care Quality and Safety, Final Report: Care, Dignity and Respect: Volume 3A, Commonwealth of Australia, 1 March 2021, p. 109, retrieved from https://www.royalcommission.gov.au/system/files/2021-03/final-report-volume-3a.pdf, accessed 21 February 2025.

[43] Retrieved from https://www.alrc.gov.au/news/equality-capacity-and-disability-in-commonwealth-laws-alrc-report/ accessed 21 February 2025.

[44] Retrieved from https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-alrc-report-124/3-national-decision-making-principles-2/national-decision-making-principles-2/ accessed 21 February 2025.

[45] Retrieved from https://disability.royalcommission.gov.au/publications/diversity-dignity-equity-and-best-practice-framework-supported-decision-making, accessed 21 February 2025.

[46] Guardianship and Administration Act 1986 (Vic).

[47] Guardianship Act 1987 (NSW).

[48] Senate Standing Committee for the Scrutiny of Bills, Report Snapshot, Scrutiny Digest 13 of 2024, paragraph 1.14, p. 56; [2024] AUSStaCSBSD 201, retrieved from https://www.aph.gov.au/-/media/Committees/Senate/committee/scrutiny/scrutiny_digest/2024/d13_24.pdf?la=en&hash=AA9F63001D5B699CC7C1216BA8617A66D149E664**Error! Bookmark not defined.**, accessed 22 October 2024

[49] Note 12.

[50] Note 6 p. 513.