

Chapter 4

Disability-specific interventions

Introduction

4.1 There are a range of therapeutic, behavioural management and other disability practices that people with disability are subjected to every day in Australian hospitals, schools and even their homes. If these practices were applied outside the disability services context, many would be viewed as an unlawful loss of personal rights and even, in some cases, as acts of violence.

4.2 The committee has received evidence from witnesses and submitters detailing cases of decision-making removed from the hands of people with disability, with regard to the medical treatments they receive, where they live, their financial affairs, the inappropriate use of restrictive practices in schools and disability services, as well as the inappropriate use of guardianship arrangements to stifle family advocacy.

4.3 As mentioned in the previous chapter on lived experience, some of this behaviour stems from the way people with disability are viewed and treated by the broader Australian society. It is clear that when people with disability are viewed and treated as different to other Australians, it becomes easier to excuse behaviour that would otherwise be completely unacceptable.

4.4 A number of important concepts around decision-making will be examined in this chapter. This chapter will also explore the consequences to individuals of the loss of legal capacity. While these consequences are many, this chapter will focus on the following:

- definitions of legal incapacity;
- therapeutic interventions which would be deemed assault in any other context, otherwise termed 'disability specific lawful violence';
- the appointment of a guardian as an alternative decision-maker;
- the excessive use of restrictive practice; and
- a person losing their 'credible witness status' in raising allegations of violence, abuse or neglect, particularly in criminal prosecutions (addressed in chapter six).

Defining legal incapacity

4.5 A fundamental principle of Australia's rule of law is that all adults, and to some extent minors, have a right to make decisions that affect their lives and to have those decisions respected. The Australian Law Reform Commission (Law Reform Commission) has noted:

...the common law recognises—as a "long cherished" right—that all adults must be presumed to have capacity until the contrary is proved. Where capacity is contested at law, the burden of proof lies with the person asserting the incapacity.¹

4.6 In some circumstances, a person is deemed to have a legal incapacity to make their own decisions. Disability-related legal incapacity refers to:

[T]he level of cognitive ability that is required before a person can lawfully do various things. Because lack of capacity can prevent people from participating in many of the activities that form part of daily life, alternative decision-making arrangements are necessary.²

4.7 Although legislation varies slightly in each state and territory, the principles that underpin a determination of legal incapacity are similar. Generally, there is a distinctly binary approach to the determination of legal incapacity—that is, a person is deemed to be either capable or not. In its report titled *Guardianship: Final Report*, the Victorian Law Reform Commission explained:

Current Victorian guardianship law draws a sharp distinction between those people who have capacity and those who do not. It does not cater for different levels of cognitive functioning. At present, guardianship law has only one response to the needs of people with impaired decision-making ability: the appointment of a substitute decision maker to make decisions on that person's behalf.³

4.8 This report found that guardianship laws relating to legal capacity need to be reformed to allow 'people to participate to the greatest extent possible in decisions that affect them'. This includes recognising that incapacity to make a decision may be decision-specific, time-specific and support-dependent:

While some people may lose some or most capacity permanently—for example, a person in the late stages of dementia—others may only temporarily lose capacity...

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- 1 Australian Law Reform Commission (Law Reform Commission), 'For your information: Australian Privacy Law and Practice' (Law Reform Commission Report No. 108), August 2008, p. 2344, http://www.alrc.gov.au/sites/default/files/pdfs/publications/108_vol3.pdf (accessed 22 October 2015). See also: *Masterman-Lister v Brutton & Co* [2003] 3 All ER 162, 169; *L v Human Rights and Equal Opportunity Commission* (2006) 233 ALR 432.
 - 2 Victorian Law Reform Commission, 'Guardianship: Final Report', April 2012, p. 98, <http://www.lawreform.vic.gov.au/projects/guardianship-final-report> (accessed 22 October 2015).
 - 3 Victorian Law Reform Commission, 'Guardianship: Final Report', April 2012, p. 98.

Similarly, an inability to make decisions in one area—such as the management of money—does not necessarily mean that a person is unable to make other decisions about other aspects of their personal circumstances, such as decisions around health care or accommodation...

Some people who struggle to make a decision alone might be capable of making their own decision with the support of a trusted person[.]⁴

4.9 The Australian Cross Disability Alliance (Disability Alliance) has pointed to Article 12 of the United Nations (UN) Convention on the Rights of Persons with Disabilities (Disability Convention), which 'establishes that all people with disability have full legal capacity'. The Disability Alliance went on to assert:

The denial of legal capacity deprives people with disability of basic human rights, including the right to give consent to medical treatment and interventions, the right to control fertility, right to bodily integrity, the right to liberty and security and the right to access to justice. The denial of legal capacity for people with disability underpins human rights violations, such as forced medical treatment and interventions, forced sterilisation and abortion, the application of restrictive practices, indefinite detention, denial of access to justice and forced living arrangements.⁵

4.10 The inquiry has received a great deal of evidence around abuse and neglect that arises as a consequence of the loss of an individual's legal capacity. The Law Institute of Victoria said:

...the denial of legal capacity (through substitute decision-making regimes in many cases) is implicated in the existence and continuation of (at least some forms of) the violence, abuse and neglect against people with a disability that occurs in institutional settings.⁶

4.11 The Queensland Aged and Disability Advocacy Service submitted that, in their experience, abuse and neglect can be caused by substitute decision makers:

...not understanding the role of a substitute decision maker, whether it is Enduring Power of Attorney (EPOA), Guardian or Administrator (all are substitute decision makers—SDM). Lack of understanding results in unchallenged authority exercised over the person by the SDM, resulting in an abusive or exploitative relationship. For example, a common situation we encounter is when the person is in a facility and not allowed to receive visits or phone calls, or see an independent doctor. Although this behaviour contravenes the general principles of the *Guardianship and Administration Act Queensland 2000 (GAA)*, it is often condoned by residential facilities that are unaware that the decision maker is in breach of their obligations.⁷

4 Victorian Law Reform Commission, 'Guardianship: Final Report', April 2012, p. 121.

5 Australian Cross Disability Alliance, *Submission 147*, p. 44.

6 Law Institute of Victoria in: Law Council of Australia, *Submission 139*, p. 16.

7 Queensland Aged and Disability Advocacy Service, *Submission 30*, p. 2.

Committee view

4.12 At the heart of the issue of legal incapacity is the concept of decision-making for a number of reasons. First, when decision-making is removed from the hands of a person, it becomes easy for the decision-maker—whether it be parent, carer, or departmental officer—to then make decisions on behalf of that individual that may seem 'to be in their best interests' but may actually be completely counter to the wishes of that person. Second, in every situation where a person has been forced to cede their own autonomy to another, there is the opportunity for abuse of that decision-making power. Finally, when the erosion of control from people with disability is normalised it makes it easier for society to accept that even those people with disability not subject to a legal guardianship order can have their will subverted as happens with the use of restrictive practices or forced medical treatments.

Supported decision-making

4.13 As discussed above, the current approach to those deemed to be legally incapacitated or unable to make their own decisions is to provide a legal guardian who will become a substitute decision maker. This is in line with Australia's reservation regarding Article 12 of the Disability Convention which relates to equal recognition before the law:

Australia declares its understanding that the Convention allows for fully supported or substituted decision-making arrangements, which provide for decisions to be made on behalf of a person, only where such arrangements are necessary, as a last resort and subject to safeguards.⁸

4.14 However, the UN Committee on the Rights of Persons with Disabilities (UN Disability Committee) has published a general comment on Article 12 in relation to the use of substituted decision-making:

On the basis of the initial reports of various States parties that it has reviewed so far, the Committee observes that there is a general misunderstanding of the exact scope of the obligations of States parties under article 12 of the Convention. Indeed, there has been a general failure to understand that the human rights-based model of disability implies a shift from the substitute decision-making paradigm to one that is based on supported decision-making.⁹

4.15 The UN Disability Committee went on to recommend:

States parties must holistically examine all areas of law to ensure that the right of persons with disabilities to legal capacity is not restricted on an

8 United Nations Convention on the Rights of Persons with Disabilities, *Declarations and Reservations: Australia*, https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en#EndDec (accessed 13 October 2015).

9 United Nations Committee on the Rights of Persons with Disabilities, *General comment No.1 (2014)*, Eleventh Session, 31 March – 11 April 2014, p.1, **Error! Hyperlink reference not valid.** (accessed 27 October 2015).

unequal basis with others. Historically, persons with disabilities have been denied their right to legal capacity in many areas in a discriminatory manner under substitute decision-making regimes such as guardianship, conservatorship and mental health laws that permit forced treatment. These practices must be abolished in order to ensure that full legal capacity is restored to persons with disabilities on an equal basis with others.¹⁰

4.16 The Law Reform Commission in its 2014 discussion paper titled *Equality, Capacity and Disability in Commonwealth Laws* highlighted that decision-making arrangements for people with disability take many forms along a spectrum, including:

- informal arrangements—usually involving family members, friends or other supporters;
- formal pre-emptive arrangements—anticipating future loss of legal capacity through appointment of a proxy, for example in enduring powers of attorney (financial/property), enduring guardianships (lifestyle) and advance care directives (health/medical); and
- formal arrangements—where a court or tribunal appoints a private manager or guardian, or a state-appointed trustee, guardian or advocate to make decisions on an individual's behalf (guardians and administrators).¹¹

4.17 The Law Reform Commission report recommended shifting away from 'substitute decision-making' where a representative makes decisions on a person's behalf, to 'supported decision-making', where people with disability are supported to make decisions for themselves. It suggested that reform of Commonwealth, state and territory law be consistent with the following national decision-making principles to 'recognise people with disabilities as persons before the law and their right to make choices for themselves':

- **The equal right to make decisions**—all adults have an equal right to make decisions that affect their lives and to have those decisions respected;
- **Support**—persons who require support in decision-making must be provided with access to the support necessary for them to make, communicate and participate in decisions that affect their lives;
- **Will, preferences and rights**—the will, preferences and rights of persons who may require decision-making support must direct decisions that affect their lives; and
- **Safeguards**—laws and legal frameworks must contain appropriate and effective safeguards in relation to interventions for persons who may require decision-making support, including to prevent abuse and undue influence.¹²

10 Committee on the Rights of Persons with Disabilities, *General comment No.1 (2014)*, Eleventh Session, 31 March – 11 April 2014, p.2.

11 Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, p. 47, <https://www.alrc.gov.au/publications/equality-capacity-disability-report-124> (accessed 21 September 2015)

4.18 In its submission, the Disability Alliance pointed out:

In September 2013 the CRPD Committee [UN Disability Committee] made a recommendation in its concluding observations to Australia that the Law Reform Commission inquiry should look at how Australian law and policy could be brought into conformity with the CRPD including in areas such as informed consent to medical treatment and access to justice.¹³

4.19 Mr David Bowen, Chief Executive Officer of the National Disability Insurance Agency, also spoke in support of the Law Reform Commission's comments on a spectrum of decision-making ability:

It is worth reflecting on the direction that that report is trying to take away from an historic divide between assessing people as either having or lacking legal capacity to one in which we recognise people's capacity to speak on their own behalf on a spectrum and that even those people who are most profoundly disabled and have limited ability to speak on their own behalf nevertheless should have their wishes and aspirations and their concerns taken into account without simply substituting somebody to make a decision for them.¹⁴

4.20 Other evidence was presented to the committee on the need to retain substitute decision-making in certain circumstances. JacksonRyan Partners submitted that there would always be some people for whom their disability meant they would be unable to participate in supported decision-making, and substitute decision-making is a necessary safety net for those people.¹⁵

4.21 The Law Council of Australia (LCA) gave moderate support to this position:

The Law Council considers that as a last resort substituted decision-making under Australian guardianship and administration laws are important elements in safeguarding against abuse and neglect. However, the Law Council considers that supported decision-making that emphasises the will and preferences of the individual should be utilised as much as possible.¹⁶

4.22 However, Dr Linda Steele of the Law Faculty, University of Wollongong told the committee:

...I think that even if we reach the decision that it is okay to still have substituted decision making there is a separate question of: are there some decisions that we should never let anyone make for someone else? That might include particular interventions in people, for example,

12 Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, p. 24.

13 Australian Cross Disability Alliance, *Submission 147*, p. 45.

14 Mr David, Chief Executive Officer, National Disability Insurance Agency, *Committee Hansard*, Melbourne, 30 June 2015, p. 38.

15 JacksonRyan Partners, *Submission 42 Attachment 12*.

16 Law Council of Australia, *Submission 139*, pp 13–14.

particular medication or particular medical procedures such as sterilisation.¹⁷

Committee view

4.23 The committee agrees with the Law Reform Commission report and its recommendations about supported decision-making. It is the committee's view that while legislative reform is clearly a necessary step to effect these reforms, more work needs to be done to investigate supported decision-making models in Australia and oversee jurisdictions to ensure that the most sustainable form of supported decision-making is implemented in Australia.

Disability specific lawful violence

4.24 The terms of reference for this inquiry provides the following definition of violence:

'violence, abuse and neglect' is broadly understood to include, but is not limited to: domestic, family and interpersonal violence; physical and sexual violence and abuse; psychological or emotional harm and abuse; constraints and restrictive practices; forced treatments and interventions; humiliation and harassment; financial abuse; violations of privacy; systemic abuse; physical and emotional neglect; passive neglect; and wilful deprivation.

4.25 What this definition does not explicitly state, and which has been made clear through evidence to the inquiry, is that many of these forms of violence are considered by the health, legal and disability service sectors to be lawful therapeutic practice:

Many of the practices would be considered crimes if committed against people without disability, or outside of institutional and residential settings. However, when "perpetrated against persons with disabilities", restrictive practices "remain invisible or are being justified" as legitimate treatment, behaviour modification or management instead of recognised as "torture or other cruel, inhuman or degrading treatment or punishment".¹⁸

4.26 Dr Steele concurred with the premise that some disability practices would, in other contexts, be considered crimes, and uses the term 'disability-specific lawful violence'. Dr Steele argued that, as well as considering the legal frameworks and practices to address and prevent violence, abuse and neglect, the committee should also consider laws which explicitly permit and legitimise violence, abuse and neglect of people with disability, generally in the medical or professional care settings, which in any other context would be considered unlawful violence. Dr Steele contended that these forms of violence include:

...constraints and restrictive practices and forced treatments and interventions which are lawfully conducted pursuant to third party consent,

17 Dr Linda Steele, Law Faculty, University of Wollongong, *Committee Hansard*, Canberra, 21 August 2015, p. 31.

18 Australian Cross Disability Alliance, *Submission 147*, pp 45–46.

court or tribunal authorisation or civil or forensic mental health legislation.¹⁹

4.27 This view was supported by the Hon Ms Kelly Vincent, a member of the South Australian Legislative Council representing the Dignity for Disability Party:

It also appears that often in the case of people with disabilities what would otherwise be recognised, quite clearly, as abuse is believed to be a natural part of the support provision.²⁰

4.28 Legal capacity to consent to treatment is a major issue within disability-specific lawful violence. Dr Steele argued that generally, non-consent is the boundary between lawful or non-lawful violence and abuse:

However, this is problematic in the context of people with disability because it is their very perceived *inability* to consent by reason of mental incapacity which has provided a legal opening to enable others to determine what can be done to their bodies. Laws relating to court or tribunal authorisation of third party consent, substituted decision making schemes and civil and forensic mental health legislation all sit within this opening.²¹

4.29 Mr Kevin Cocks, the Queensland Anti-Discrimination Commissioner, made similar statements but instead referred to 'structural violence', which he defined as:

...a form of violence wherein some social structures or social institutions may harm people by preventing them from having their basic human rights met.²²

4.30 Mr Cocks also described the devastating impacts that structural violence has on the lives of people with disability:

For me the term 'structural violence' is to act as an umbrella to encapsulate many different forms of various social and institutional failings that have real if not always immediately appreciable consequences, and often quite devastating consequences in people's lives. This is particularly true across cultures and time for people with disability. People with disability are subject to multiple and aggravated forms of human rights violations. They occur every day in every region of every state and territory in Australia. Virtually every Australian with disability encounters human rights violations at some point in their lives, and many experience it every day of their lives. In Australia it is possible for people with disability to die of starvation in specialist disability services, to have life-sustaining medical treatment denied or withdrawn in health services, to be raped or assaulted without any reasonable prospect of these crimes [being] detected, investigated or prosecuted by the legal system, and to have their children

19 Dr Linda Steele, School of Law University of Wollongong, *Submission 94*, p. 3.

20 Ms Kelly Vincent, MLC, *Committee Hansard*, Adelaide, 28 August 2015, p. 56.

21 *Submission 94*, p. 6.

22 Mr Kevin Cocks, *Committee Hansard*, Brisbane, 16 October 2015, p. 43.

removed by child protection authorities on the prejudiced assumption that disability equates to incompetent parenting.²³

Guardianship

4.31 People with an intellectual incapacity can be subject to guardianship and financial administration orders to protect their health and welfare—this is administered by tribunals and courts within each jurisdiction. In these circumstances people with an intellectual incapacity are considered to have legal incapacity to make autonomous decisions about their lifestyle, health, accommodation, work and financial affairs.

4.32 Guardianship may be sought for people who have an intellectual disability, psychiatric disability (like schizophrenia), neurological disability (like dementia), developmental disability (like autism), brain injury or physical disability that prevent that person from communicating their wishes.²⁴

4.33 Not all people with an intellectual disability have legal incapacity, nor are all people with intellectual disability unable to make any decisions about their lives. The Intellectual Disability Rights Service stated that decision-making capacity should be considered on a spectrum between full autonomy and substituted decision-making and 'in between is a scale of informal supported decision-making that varies from time to time and from decision to decision'.²⁵ Further to this, 'supported or substituted decision-making do not require a formal guardian appointed by order of a tribunal or court'.²⁶

4.34 A formal order of guardianship can be exercised by a person, a group of people, the public guardian, an adult guardian or Public Advocate.²⁷

4.35 Different jurisdictions have different frameworks for how guardianship is administered. For example, in many jurisdictions there is a public advocate but in New South Wales (NSW) there is a public guardian. Public advocates have stronger powers than public guardians. In 2010, a NSW parliamentary inquiry recommended that NSW switch to a public advocate to enhance adult protective services. For

23 Mr Kevin Cocks, Commissioner, Anti-Discrimination Commission, Queensland, *Committee Hansard*, Brisbane, 16 October 2015, p. 43.

24 Intellectual Disability Rights Service, *Guardianship and administration laws across Australia*, p. 13, http://www.idrs.org.au/pdf/Guardianship_and_administration_laws_across_Australia_by_Ben_Fogarty.pdf (accessed 7 October 2015)

25 Intellectual Disability Rights Service, *Guardianship and administration laws across Australia*, p. 2.

26 Intellectual Disability Rights Service, *Guardianship and administration laws across Australia*, p. 2.

27 Intellectual Disability Rights Service, *Guardianship and administration laws across Australia*, p. 13.

example, they could identify an adult with an intellectual disability and make an application on behalf of that person to have a guardian appointed.²⁸

4.36 In NSW, the Civil and Administrative Tribunal (NCAT) determines 'applications about adults with a decision-making disability who are incapable of making their own decisions and who may require a legally appointed substitute decision maker'. Where NCAT deems that a person is incapable of making their own decisions, it may decide to 'make a guardianship order to appoint a private guardian (family member or friend) and/or the NSW public guardian'. NCAT can also make decisions relating to consent, financial management orders, and reviewing guardianship appointments.²⁹

4.37 The submission from the Disability Alliance put forward the proposition that guardianship systems across Australian are different enough to cause confusion and difficulty in challenging guardianship orders. The Disability Alliance further contended that although there is inconsistency in how guardianship laws operate, there are key common themes in that all of them are in breach of Australia's international human rights obligations, and guardianship can itself create environments where violence, abuse and neglect occurs:

Guardianship law and mental health legislation are examples of current legislative frameworks that, by their very nature, give rise to the perpetration of torture and ill-treatment of people with disability in institutional and residential settings. State and territory guardianship and mental health laws primarily regulate the area of legal capacity and substitute decision-making in Australia. While state and territory laws in this area vary, they all breach, are inconsistent with, or fail to fulfil Australia's obligations under international human rights law, including for example Article 12 of the Convention on the Rights of Persons with Disabilities (CRPD). These state and territory laws provide different and inconsistent tests for assessing a person's ability to exercise legal capacity, which leads to uncertainty, confusion and inappropriate application of legal principles. There is no nationally consistent legislation that outlines principles and provisions for assessing what constitutes a valid decision that should be recognised by the law. Moreover, existing legislation does not focus on measures (such as supported decision making) that would enable or support a person with disability to make decisions so that their decisions are recognised as valid before the law.³⁰

4.38 In discussing systemic issues around guardianship, the North Australian Aboriginal Justice Agency (NAAJA) presented evidence that Aboriginal and Torres Strait Islander peoples are over-represented in the adult guardianship system, with 50

28 Mr Graeme Smith, Public Guardian, Office of the Public Guardian, New South Wales Department of Justice, *Committee Hansard*, Sydney, 27 August 2015, p. 24.

29 NSW Civil and Administrative Tribunal, *Guardianship Division*, August 2015, <http://www.ncat.nsw.gov.au/Pages/guardianship/guardianship.aspx> (accessed 7 October 2015).

30 Australian Cross Disability Alliance, *Submission 147*, pp 59–60.

per cent of people subject to guardianship being Indigenous, while only representing 30 per cent of the population. NAAJA further stated:

...the number of people under guardianship in the [Northern Territory] is 8 times as many as the next number of people under guardianship in the next highest Australian jurisdiction (NSW).³¹

4.39 NAAJA contended that this creates an imperative to ensure that Aboriginal and Torres Strait Islander peoples' particular circumstances are taken into account in developing guardianship systems, particularly for the high numbers of Indigenous people living in remote communities or on traditional lands.³²

4.40 The Disability Alliance pointed to the over-representation of people living in institutions in the guardianship system:

People with disability in institutional settings are more likely to be subject to guardianship proceedings for the formal removal of their legal capacity. This facilitates and may even authorise forced interventions.³³

4.41 Of particular concern, the committee heard that existing legal frameworks do not recognise the role played by informal advocates, particularly family members, when making decisions for or on behalf of people with disability. Queensland Aged and Disability Advocacy Inc. (QADA) argued that the main systemic response to abuse is to be 'protective', through the appointment of a substitute decision maker.³⁴ The interplay between guardianship and informal advocacy is discussed in greater detail in chapter eight.

4.42 In its report on legal rights for people with disability, the Law Reform Commission recommended that the role of informal advocacy be respected. It advised that where a representative is appointed to make a decision for a person who requires decision-making support, the representative 'must give effect to what the person would likely want, based on all the information available, including by consulting with family members, carers and other significant people in their life'.³⁵

31 North Australian Aboriginal Justice Agency, *Submission 138*, p. 4.

32 North Australian Aboriginal Justice Agency, *Submission 138*, p. 4.

33 Australian Cross Disability Alliance, *Submission 147*, p. 17.

34 *Submission 30*, p. 3.

35 Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, p. 12.

Committee view

4.43 As discussed further in chapter six, the committee supports the implementation of a supported decision-making model that recognises a graduated continuum of legal capacity for people with disability. Within this model, the Law Reform Commission has recommended that the 'role of persons who provide decision-making support should be acknowledged and respected—including family members, carers or other significant people chosen to provide support'.³⁶

Misuse of guardianship by facilities

4.44 A common theme across multiple submitters, was that guardianship orders are often misused by disability service facilities or other organisations to streamline or create efficiencies in service delivery:

It is very significant, and yet we have very good guardianship legislation in Queensland that says that the voice of the person and their informal supporter should be taken into account. It often—I would say more than often—does not happen that way. In instances where a service provider does challenge that guardianship—in some cases it is a hospital. They want to move the person out, they know that there is no other accommodation arrangement, they say, 'We're going to send you to a nursing home', the person does not have a capacity issue and says, 'No, I don't want to go', but they will apply for guardianship anyway just to get them out of the hospital. And if a parent is an informal supporter then quite often if they have encountered difficulties with the service provider and there are restrictive practices involved they will feel the need to seek guardianship just to have that authority—which they should not have to do, because, even though it is not meant to strip authority and autonomy from the person, in effect that is what happens in practice. Everyone then deals with the guardian. If the service provider does not like the decisions made by the guardian they will certainly challenge their authority and seek to have them removed.³⁷

4.45 This experience was echoed by Mr Neal Lakshman of Speaking Up For You:

I had a gentleman who was in a nursing home. A social worker put in an application for a guardianship. He [the subject of the guardianship application] never knew that the hearing was on and then when he actually went the tribunal found that he had [legal] capacity. If you do not go, it is all—the other issue with some of the hearings is that of restricted practices. All the psych reports, everything, are put in by [Disability Services Queensland (DSQ)] psychs and [Occupational Therapists] and other persons. They work for DSQ and DSQ wants the person to live in the

36 Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Law Reform Commission Report 124, August 2014, p. 11, <https://www.Law Reform Commission.gov.au/publications/equality-capacity-disability-report-124> (accessed 21 August 2015).

37 Ms Michelle O'Flynn, Director, Queensland Advocacy Inc. (QAI), *Committee Hansard*, Brisbane, 16 October 2015, p. 5.

facility because they do not want them to live elsewhere because it is easier for them. So the information going into the guardianship hearing is by the same organisation or place where you are going to be living. I find that quite problematic.³⁸

4.46 Other submitters presented evidence that the guardianship system is managed in favour of the needs of service organisations, instead of the needs of people with disability or their families and advocates:

Many of our clients report that their doctor also has a professional affiliation to the facility or the SDM. This results in a violation of confidentiality toward the person with a disability. Rather than keeping the information confidential to the person with a disability, there is often a strongly perceived lack of impartiality by the treating doctor. This can result in a report that aligns with the needs of the facility or the SDM, rather than one that accurately reflects abilities of the individual with a cognitive disability, or no report being produced at all. Often our clients realize this and are reluctant to seek assessment from "their" doctor. It results in difficulties in accessing reports, as often the person in an institutional setting has difficulties accessing another doctor in the community, without attracting more challenges from the institution.

Many of our volunteer advocates spend time trying to access alternative medical reports from another independent doctor. This activity is made more difficult when the SDM is unwilling to pay for a visit or report, which is likely when the purpose of the report is to challenge their authority over the person with a disability.³⁹

4.47 In her submission, Ms Julie Phillips wrote that she believed the close working relationship with the Victorian Office of the Public Advocate (OPA) and the Victorian Department of Health and Human Services (DHHS) was 'at times to the detriment of people with disabilities':

However more importantly, the willingness of OPA to provide guardians for people with disabilities could be seen to be assisting DHHS to commonly make guardianship applications against parents, simply when the parents will not agree with something DHHS intends to do to their family member.⁴⁰

4.48 In their submission, Communication Rights Australia and the Disability Discrimination Legal Service presented similar evidence:

...a common mode of response is often a guardianship application made for the individual in an attempt to bypass parents and appoint someone who is more amenable to DHHS/contractors and their decision-making.

38 Mr Neal Lakshman, Advocacy Worker, Speaking Up For You Inc., *Committee Hansard*, Brisbane, 16 October 2015, p. 39.

39 QADA, *Submission 30*, pp 6-7.

40 Ms Julie Phillips, *Submission 131*, p 58.

Regrettably, this might often be the Office of the Public Advocate Guardianship Program.⁴¹

4.49 Moreland Community Legal Centre discussed a number of cases where guardians blocked lawyers or advocates access to individuals:

The lawyers contacted both the professional Guardian and private Administrator to seek permission to visit the woman. She was granted permission and booked an interpreter and together they visited the site. The professional Guardian separately contacted the Aged care residential accommodation provider and advised them that permission was not granted and as a result they refused entry to both lawyer and interpreter. There was no alternative but to make an application to VCAT (Victorian Civil and Administrative Tribunal) to direct the Guardian to permit a professional visit.⁴²

4.50 These examples above have been presented by submitters as a small sample of the cases of abuse of guardianship their organisations are faced with on a weekly basis.

Inappropriate decision-making

4.51 The committee has received evidence detailing exclusionary decision-making processes whereby the guardian makes decisions without involving the individual in the process. Ms Julie Phillips notes that in Victoria, guardians from the OPA 'can make decisions for people with disabilities without meeting them and in direct defiance of family wishes'. Another issue is that the DHHS will often argue for a public trustee, such as the OPA, to be appointed as a guardian even when family members are capable and willing to fulfil this function:

DHHS made a guardianship application in relation to "Jane" who has an intellectual disability and severe language disorder. The only reason for the application was that Jane's mother, Mrs Smith, would not give her permission for Jane to be placed in an inappropriate accommodation service. The track record of DHHS in relation to Jane had been one of incompetence, and inability to effectively manage challenging behaviours.

Mrs Smith has been asking for a Functional Behaviour Assessment for approximately one year.

VCAT [Victorian Civil and Administrative Tribunal] helpfully supported DHHS, as is often the case, and a Guardian from OPA was appointed. Mrs Smith was not proven to be (or accused of being) anything other than a caring mother who was attempting to uphold the rights of her daughter. Despite not being able to find any significant fault with Mrs Smith, she was not given guardianship rights, and they were awarded to OPA.⁴³

41 Communication Rights Australia and the Disability Discrimination Legal Service, *Submission 78*, p. 9.

42 Moreland Community Legal Centre, *Submission 130*, p. 3.

43 Ms Julie Phillips, *Submission 131*, pp 58–59.

4.52 Cheryl McDonnell described to the committee the interactions she had with the financial manager assigned to their daughter:

Our experience of dealing with [Terri's] case manager was that she would make decisions on Terri's behalf regardless of what Terri wanted or needed and regardless of what myself or Terri's siblings wanted for Terri.⁴⁴

4.53 Ms McDonnell described two circumstances in which Terri's guardian was unable to make appropriate choices for Terri, even with Ms McDonnell and her husband being there to advocate and help guide the guardian to what should be a sensible decision with a sensible outcome.⁴⁵

4.54 In some cases, guardians are improperly influencing decisions relating to medical treatment:

We have received two reports from members of the public concerned that the nominated carer/guardian is abusive and that their capacity to influence treating clinical teams formed part of the pattern of abuse and control (such as influencing decisions about admission or discharge and controlling access to advocates) In both cases, the consumers were male and Western Australia has no domestic violence services for male victims of domestic violence, nor domestic violence programs tailored to the needs of mental health consumers.⁴⁶

4.55 One of the more disturbing pieces of evidence is the threat of forced public guardianship as a means of enforcing silence and compliance on those families or individuals who are deemed to be 'troublemakers':

Young people with disabilities and/or their families who make complaints to disability service providers about abuse and neglect are often ignored or ridiculed. Many are categorised as troublemakers, as unnecessarily combative, or even mentally ill, for refusing to withdraw complaints about poor treatment. Some are told that if they do not withdraw their complaints, the service or government will apply or challenge for guardianship so that they can have ultimate decision-making control over the young person's life.⁴⁷

4.56 Youth Disability Advocacy Service related the story of "Jack" and how the coercive threat of guardianship was held over him and his family:

"Jack", a 17-year-old male living in a Community Residential Unit, who has autism and uses non-verbal communication, was one-of-two people allegedly sexually assaulted by a new co-resident with a well-known history of sex offending, not long after he moved in to the Unit. The families of the existing residents made multiple complaints to the service provider and to

44 Ms Cheryl McDonnell, *Submission 37*, p. 7.

45 *Submission 37*, pp 7–8.

46 Consumers of Mental Health WA, *Submission 110*, p. 17.

47 Youth Disability Advocacy Service, *Submission 88*, p. [3].

the DHHS about the inappropriate placement before the alleged assault took place, but were dismissed as over-zealous and intolerant.

"Jack's" family were not informed by the service provider about the alleged assault but from the family of the other victim, who needed medical attention for his injuries. The staff member working at the time of the alleged assault did not take steps to prevent the attacks, hiding himself in the locked staff area. He was not dismissed by the service provider despite admitting negligence "Jack's" family are lobbying to have him moved into more suitable housing but must negotiate these new arrangements with the same DHHS staff who have threatened to apply for guardianship if they persist with their complaints.⁴⁸

4.57 Another submitter wrote that guardianship relationships can become overly 'functional' in nature, and guardianship laws are mis-used to gag parents or advocates who complain:

From my experience, once a Guardianship Order is made, the person simply becomes a commodity. The 'individual' ceases to exist. That person is stripped of any human rights, freedoms or entitlements to interact within the community or maintain family relationships as they would wish. The protected person and the family and friends are also subject to legal action by the Tribunal if they publicly identify the protected person and their complaints whilst under a guardianship order –essentially a legal gag clause. This outcome was NOT the intention of the legislation of the Guardianship Act nor was it the outcome that the Principles and Guidelines of the UNCRPD intended to achieve.⁴⁹

Committee View

4.58 The loss of legal capacity has multiple flow-on consequences, one of which is the appointment of guardianship. In many cases guardianship is a positive protective measure, but in too many cases the appointment of a guardian can have a severe negative impact on people's lives:

- The guardianship process could be considered an abuse itself, particularly because of the loss of rights it entails.
- In more serious cases, guardianship could be sought in order to enact abuse or neglect:
- Evidence has shown that even well-meaning guardians can inflict abuse or neglect through lack of understanding of their role or by being risk averse.
- The fact that a vulnerable person may be prevented through guardianship arrangements from lodging a complaint is also a form of abuse. In many cases, the prevention of reporting violence, abuse and neglect leads to the indefinite perpetuation of inappropriate actions.

48 Youth Disability Advocacy Service, *Submission 88*, p. [3].

49 Name Withheld, *Submission 106*, p. 2.

4.59 It is clear that the guardianship arrangements in all jurisdictions require some reform, including improved guidelines on appropriate decision-making through to oversight of the guardians themselves.

Parental guardianship issues

4.60 Parental issues around guardianship were also raised by different submitters. Ms Marion Bright told the committee of difficulties she faced in trying to advocate for her daughter, an adult with an intellectual impairment. Ms Bright was the sole carer for her daughter, and did not obtain formal guardianship, which impaired her capacity to seek information about her daughter's case from the relevant government department:

He said: 'Oh, but this is very sensitive information. We have to protect her rights.' Hello? What rights? Then he asked if I had guardianship, and I said, 'No, I'm her mother.' He was being particularly aggressive. Let me finish. I was shaking, but I thought, 'I can't say anything, because I need this information, because I want to get justice for Lauren.' Then he said, 'Oh, where does Lauren live?' I said, 'With me,' and then his attitude changed completely and he told me, 'Oh, we get inquiries for freedom of information all the time, and it's just families wanting money because they find out that a person they've had nothing to do with has a lot of money.' That had no relevance to me. Then, before I hung up, I said to him, 'So should I look at getting guardianship?' He said, 'Oh, no; she lives with you.' I could have thrown the phone through the wall. I was already distressed.⁵⁰

4.61 The NSW Office of the Public Guardian discussed the difficulties that parents had when their children with intellectual disability reached adulthood, which triggered the loss of parental legal rights to seek information or advocate on their children's behalf without going through a formal guardianship process:

Attorneys-general across Australia have been in receipt of representations from various groups suggesting that, when a person reaches the age of 16 or 18, where their family have been their key source of support historically, there would be some sort of automatic or streamlined conversion of the parental responsibility into guardianship. I know for example that the Victorian parliament considered that issue. But to my knowledge none of the parliaments in any of the jurisdictions has actually agreed to provide some sort of automatic guardianship to families in the absence of an evaluation of the circumstances.⁵¹

4.62 Other evidence presented to the inquiry put forward the position that even well-meaning guardians can have a negative effect on a person's life, due to the different goals the guardian may have for the outcomes of decisions. Mr Robbi Williams, Chief Executive Officer of disability consultancy firm JFA Purple Orange told the committee:

50 Ms Marion Bright, *Committee Hansard*, Melbourne, 30 June 2015, p. 29.

51 Mr Graeme Smith, Public Guardian, Office of the Public Guardian, New South Wales Department of Justice, *Committee Hansard*, Sydney 27 August 2015, p. 23.

Guardians will typically operate with the notions of safety and duty of care uppermost in mind and will often have a bias towards more conservative models of support that reflect that duty of care, rather than those patterns of support that bring greater proximity to ordinary life chances. The problem with proximity to ordinary life chances is that it comes with risk. There is a risk in life. Anything that we try to undertake in life will involve a modicum of risk. It is about how we manage that risk and stack the odds in favour of success, rather than trying to avoid the presence of risk altogether.⁵²

4.63 However, strong evidence was received by the committee on the important protective role that guardianship plays, particularly for people who lack family or social supports:

This client was aged 47 and was in an aged-care facility and had an intellectual disability, no speech and a physical disability. We received the referral from a day service provider, who had the following concerns: 'On two occasions, this client arrived with dry faeces in her pubic area, which day staff observed during personal care routines.' They reported these observations in the daily communication diary between their service and the aged-care facility, but no action was taken to clean and dress the client properly. There were signs of skin deterioration in the area and a distinct lack of personal care...

...Our advocate investigated the matter and discovered that this particular young person—47, in an aged facility—had no family support network, did not have the capacity to make informed decisions, did not have a legal guardian and had been taken off the electoral roll by the aged-care facility. The care plan did not stipulate how to shower or what equipment to use during showering and dressing. The client had not received medical attention for her swallowing difficulties. She had not been provided with a half-price, multipurpose taxi program card. She did not have any support to access the community on weekends. She did not have a companion card. She had untreated rashes on her arms and legs. She had long periods of time where she had not been seen by a GP because there was no backup plan when the GP who was assigned to the nursing home was on leave. She had clothing that was communally laundered, but her items were not named. She had a bowel chart that showed long periods of time when there was no bowel movement recorded. She was being left in front of the TV while the elderly residents were being fed their evening meal.

Three of my advocates worked on this case over a period of time. We eventually addressed many of the problems by applying to the Victorian Civil and Administrative Tribunal and getting a guardianship order in favour of the Office of the Public Advocate. Unfortunately, the client passed away four months after that guardianship order was enforced by

52 Mr Robbi Williams, Chief Executive Officer, JFA Purple Orange, *Committee Hansard*, Adelaide, 28 August 2015, p. 57.

VCAT. She died from medical complications associated with the swallowing and the chest infections.⁵³

Committee view

4.64 Evidence presented to the committee shows that in many cases, parents of people with disability want to maintain a continued parental interest in the welfare of their children well into their adulthood. However, the committee has heard that what appears to be an obvious parental expectation, is in many cases not realised.

4.65 The committee sees a need for cross jurisdictional work, to develop a national system whereby parents of people with disability, who require advocacy or decision-making assistance, have that role formally acknowledged in some capacity when their children turn eighteen years of age.

Financial abuse and neglect

4.66 The committee received a number of submissions regarding financial abuse of people with disability, much of which was not relevant to the terms of reference because it did not relate to people living in institutions or residential care facilities. However, given the volume of evidence this is clearly an issue of great concern in the community.

4.67 In 2014, it was reported that staff at the Australian Capital Territory (ACT) Public Trustee had allegedly embezzled \$1.65 million from people whose assets it managed in trust, including those subject to guardianship orders.⁵⁴ This is not an isolated case, there are many other examples of public trustees or public guardians with a financial function acting improperly and abusing their positions of trust, including in South Australia⁵⁵ and the Northern Territory:

Mr G is from a remote community and around three years ago the Public Guardian [PG] was appointed as his financial manager. For the first two years of that order the PG did not take control of Mr G's finances and he continued to suffer financial exploitation. This included a well meaning non-indigenous community member unofficially assuming management of Mr G's finances - and having his Centrelink benefits deposited directly into

53 Mr Trevor Carroll, Executive Officer, Disability Justice Advocacy Inc., *Committee Hansard*, Melbourne, 30 June 2015, p. 24.

54 Michael Inman, 'Staff member sacked, second quits at ACT Public Trustee as alleged \$1.65 million fraud probed', *The Canberra Times*, 23 February 2015, <http://www.canberratimes.com.au/act-news/staff-member-sacked-second-quits-at-act-public-trustee-as-alleged-165-million-fraud-probed-20150216-13g0wy.html> (accessed 7 October 2015).

55 See: Michael Owen, 'SA Public Trustee treats clients as "inconveniences", inquiry hears', *The Adelaide Advertiser*, 16 November 2009, <http://www.adelaidenow.com.au/news/public-trustee-squandering-money/story-e6freol3-111118060617> (accessed 7 October 2015); Ms June Walker, *Submission 113d*, p. [7]; Parliament of South Australia, *Inquiry into the Office of the Public Trustee: Report of the Statutory Authorities Review Committee 51st Report*, 1 December 2009, <https://www.parliament.sa.gov.au/Committees/Pages/Committees.aspx?CTId=5&CId=303> (accessed 7 October 2015).

her personal account. At the time the PG took control of Mr G's Centrelink payments he had no money in his bank account.

The financial statements provided with Mr G's next Court review indicated that in the first 3 months under the management of the PG, Mr G had saved \$7,529.97 (after expenses for accommodation, bank fees, food and personal spending had been deducted). It is arguable that had the PG taken control of his finances when the Court ordered it to, he would have saved an estimated \$65,000 (over the two years and two months from when the adult guardianship order began to when the PG assumed control of Mr G's finances).⁵⁶

4.68 Other evidence was submitted where service delivery agencies were neglectful in their financial management of resident's monies:

Elise has lived in a group home with several other people for 10 years. She is middle aged with intellectual disability and has difficulty with communication. She receives DSP paid into her personal bank account and staff take her to the bank to withdraw her DSP which is then paid into the household working account run by the group home. Two years ago it was discovered that \$9,000 could not be accounted for by the group home. Elise needed her advocate to help her complain. The advocate sought assistance from IDRS. Initially the NGO promised financial statements but then said the matter would be investigated by its own auditors. The matter was reported to the police. Five months later there were still no accounts and the NGO refused to answer questions posed by the advocate. In the end it was a year before any accounts were provided. The police advised the advocate that so many people had access to the account that they did not have enough evidence to charge anyone. When the police asked to interview staff, they refused to be interviewed. Some of Elise's money was finally reimbursed but no account was given of how the reimbursement was calculated. The advocate believed the amount was at least \$1,500 short. No-one was charged by police. No action was taken against the service provider. The advocate suspected there were 5 other residents with similar stories.⁵⁷

4.69 Financial abuse is not limited to public trustees or organisations. The committee has been furnished with examples of individuals who ingratiate themselves into the lives of a person with disability beyond their reasonably expected service capacity. It is not uncommon for these people to abuse the trust placed in them by a person with disability:

Abuse by a SDM [substitute decision-maker] is not regarded as a crime or misdemeanor, or an unlawful activity. For example, there is no quick, effective and low cost way for a matter to be prosecuted in the lower courts to secure restitution of monies stolen by an SDM. QADA is aware of several cases of financial abuse perpetrated by EPOA's or private administrators.

56 North Australian Aboriginal Justice Agency, *Submission 138*, p. 12.

57 Intellectual Disability Rights Service, *Submission 128*, pp 5-6.

For example, a private administrator, (estranged family member) was appointed by QCAT, when the person (Tony) was in a coma. The person was expected to make a full recovery from their disability within 18mths. The person made a full cognitive recovery, but was left with severe physical deficits, resulting in their being placed, as a young person in an aged care facility.

The administrator (who was appointed for 5 years and not required to fulfil any of the usual reporting duties of administrators) took all of the person's financial assets and then did not regularly pay fees.

QCAT declared the person capable and issued enforceable directions regarding reclaiming outstanding monies.⁵⁸

Committee view

4.70 The committee notes that the number of submissions received on the abuse of people with disability in the general community, including financial abuse, shows there is a significant problem. The committee is of the view that this issue requires greater oversight and investigation.

Restrictive Practice

4.71 A key form of 'disability specific lawful violence' is the use of restrictive practices in the disability, health and education sectors as a means of preventing people—mostly with disability—from hurting themselves or others.

4.72 The Australian Department of Health defines restrictive practice as:

The use of interventions that have the effect of restricting the rights or freedom of movement of a person in order to protect them. Examples include lap belts, hand mitts, removing mobility aids such as walking frames and sedation of a person to control their behaviour.⁵⁹

4.73 The Commonwealth's *National Framework for Reducing and Eliminating the Use of Restrictive Practices* (Restrictive Practice Framework) defines restrictive practice 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.' The Restrictive Practice Framework defines the various forms as:

- seclusion: the sole confinement of a person with disability;
- chemical restraint: the use of medication for the primary purpose of influencing a person's behaviour or movement;

58 Queensland Aged and Disability Advocacy Service, *Submission 30*, p. 3.

59 Australian Government Department of Health, *Decision-making tool: Supporting a restraint free environment in residential aged care*, 2012, p. 24, https://www.dss.gov.au/sites/default/files/documents/09_2014/residential_aged_care_internals_fa3-web.pdf (accessed 22 October 2015).

- mechanical restraint: the use of a device to prevent or restrict a person's movement for the primary purpose of influencing a person's behaviour;
- physical restraint: the prolonged use of physical force to subdue movement for the primary purpose of influencing a person's behaviour; and
- additional restrictive practices of:
 - Psycho-social restraints: the use of 'power-control' strategies;
 - Environmental restraints: restricting a person's free access to all parts of their environment; and
 - Consequence driven practices: the withdrawal of activities or items.⁶⁰

4.74 Restrictive practices are purported to be used in the disability, health and education sectors as a means of preventing people—mostly with disability—from hurting themselves or others. The Law Reform Commission report found that:

[T]here are concerns that such practices can also be imposed as a 'means of coercion, discipline, convenience, or retaliation by staff, family members or others providing support'. Such practices may infringe a person's human rights. As a result, there are significant concerns about the use of restrictive practices in Australia. For example, the United Nations Committee on the Rights of Persons with Disabilities (UNCRPD) has stated that it

'is concerned that persons with disabilities, particularly those with intellectual impairment or psychosocial disability, are subjected to unregulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraints and seclusion, in various environments, including schools, mental health facilities and hospitals'.⁶¹

4.75 The committee has received evidence that argued the misuse of 'restrictive practices' is viewed as a form of abuse. This evidence will be examined later in this chapter.

We would prefer not to use the sanitised language of restrictive practices, and instead call them what they are, such as bondage, drugging and being locked up. If you did that to a person who did not have a disability it would be a criminal offence.⁶²

60 Department of Social Services, *National Framework for Reducing and Eliminating the use of Restrictive Practices in the Disability Services Sector*, November 2014, <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?HTML> (accessed 27 October 2015).

61 Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, May 2014, p. 195.

62 Ms O'Flynn, Director, Queensland Advocacy Inc., *Committee Hansard*, Brisbane, 16 October 2015, p.1.

Summary of restrictive practice across the jurisdictions

4.76 Regulation of restrictive practices 'occurs mainly at a state and territory level', with the Commonwealth attempting to provide nationally consistent guidelines through the Restrictive Practice Framework. The Restrictive Practice Framework was endorsed by the Council of Australian Governments Disability Reform Council in March 2014 and intended to reduce the instances of restrictive practices within the mental health and disability services sectors.⁶³ The education sector is not captured in the Restrictive Practice Framework. The issue of restrictive practices in schools is discussed later in this chapter.

4.77 Kim Chandler et al in their 2014 comparative analysis paper, notes that only four jurisdictions in Australia currently regulate restrictive interventions and practices—these are Victoria, Queensland, Tasmania and the Northern Territory—as opposed to providing voluntary guidelines for service providers and government agencies to adopt. This paper summarises:

The focus of these restrictive practices legislative regimes is on regulating the standard of care in disability services either provided by or funded by state government human services departments. They reflect the dual concern with ensuring safeguards and an adequate standard of care and support in government-provided services as well as ensuring service providers are protected from civil and criminal liability for the use of such practices.

These regimes therefore do not extend to the use of restrictive practices on people with intellectual impairment in hospitals and other health facilities, aged care facilities, other supported residential services (such as boarding houses) or where care is provided by family or private carers. Nor, except perhaps in the case of Tasmania where the regime applies to services provided by a disability service provider and a 'funded private person',³² would they apply to the purchase of services by people with disability from non-funded disability services. That is, if a person with disability was provided with funds for their disability, from either a state government department, or the National Disability Insurance Agency, and with those funds purchased services from a non-funded disability service, then the restrictive practices regulatory regimes would arguably not apply.⁶⁴

A summary of the different legislation, and the agencies and departments across all Australian jurisdictions can be found in Table 4.1.

63 Department of Social Services, *National Framework for Reducing and Eliminating the use of Restrictive Practices in the Disability Services Sector*, November 2014, <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?HTML> (accessed 17 August 2015). See also: Australian Cross Disability Alliance, *Submission 147*, pp 46–47.

64 Kim Chandler, Lindy Willmott and Ben White, 'Rethinking Restrictive Practices: A Comparative Analysis', *QUT Law Review*, vol. 4, no. 2, 2014, p. 97.

Table 4.1: Summary of relevant legislation and policies relating to the use of restrictive practices in all Australian jurisdictions

Jurisdiction	Legislative/policy framework	Agencies and departments responsible
Commonwealth	<i>National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Services Sector</i>	- Social Services (Cth)
New South Wales	<i>Behaviour Support Policy</i> <i>Aggression, Seclusion and Restraint in Mental Health Facilities in NSW (June 2012)</i> <i>Guardianship Act 1987</i> <i>Children and Young Persons (Care and Protection) Act 1998 (and Regulations)</i>	- Family and Community Services - Health
Victoria	<i>Disability Act 2006</i> <i>Mental Health Act 2014</i> Victorian Chief Psychiatrists Guideline, <i>Seclusion in Approved Mental Health Services (2011)</i> <i>Restraint of Student Policy (2015)</i>	- Disability Services - Health - Education
Queensland	<i>Disability Services (Restrictive Practices) and Other Legislation Amendment Act 2014</i> <i>Mental Health Act 2000 (and Mental Health Act 2000 Resources Guide(2012))</i> <i>Policy Statement on Reducing and Where Possible Eliminating Restraint and Seclusion in Queensland Mental Health Services (2008)</i>	- Communities, Child Safety and Disability Services - Health
Western Australia	<i>Mental Health Act 1996</i> <i>Voluntary Code of Practice for the Elimination of Restrictive Practices 2014</i>	- Disability Services Commission
South Australia	<i>Mental Health Act 2009</i> <i>Disability Services Act 1993</i> <i>Guardianship and Administration Act 1993</i> <i>Children's Protection Act 1993</i> <i>Safeguarding People with Disability—Restrictive Practices Policy 2013</i>	- Health - Communities and Social Inclusion
Tasmania	<i>Disability Services Act 2011</i> <i>Mental Health Act 2013</i>	- Disability Services - Health
Northern Territory	<i>Mental Health and Related Services Act 1994</i> <i>Disability Services Act 2012</i>	- Health - Disability Services
Australian Capital Territory	<i>Mental Health (Treatment and Care) Act 1994</i> <i>Mental Health Act 2015</i>	- Health

4.78 The following section notes a number of characteristics that define the approaches used by some of the different jurisdictions.

Western Australia

4.79 In Western Australia, the Disability Services Commission (DSC) has recently updated its *Code of Practice for the Elimination of Restrictive Practices*. This voluntary code of practice 'provides the basis for the disability sector to develop operational policy and guidelines for eliminating the use of restrictive practices' and 'applies to all services provided and funded by the [DSC] for children and adults with disability'.⁶⁵ The committee notes the DSC has undertaken engagement with a wide range of stakeholders to develop 'a decision-making flowchart for challenging behaviour and restrictive practices, a greater emphasis on Positive Behaviour Support approaches including person-centred planning, and a greater focus on the role of Positive Behaviour Support Panels'.⁶⁶

4.80 However, the committee notes the voluntary nature of the code ultimately means these practices are not regulated and, as such, there is little likelihood of them being reduced or eliminated.

Queensland

4.81 In 2014, after consultations, the Queensland Government made a series of changes to the state *Disability Services Act 2006* and the *Guardianship and Administration Act 2000* in an effort to reduce or eliminate restrictive practices. The key changes are:

- emphasising the need for a positive behaviour support approach, not just where restrictive practices are required;
- introducing a principle that restrictive practices should not be used as a form of punishment and a requirement for service providers to provide a statement to adults, their families and carers about the use of restrictive practices;
- requiring disability service providers to report to the department on the use of restrictive practices.⁶⁷

65 Western Australia Disability Services Commission, *Code of Practice for the Elimination of Restrictive Practices*, November 2014, p. 1, <http://static1.1.sqspcdn.com/static/f/1546495/25715521/1417183469157/Code+of+Practice+Final+Nov+2014.pdf?token=%2B60ZC7bb7zwPk%2BOG6FC13ZVOS8%3D> (accessed 23 October 2015).

66 Western Australia Disability Services Commission, *Positive Behaviour Framework Disability Sector Update*, Edition Number 6, November 2014, p. 3, <http://www.disability.wa.gov.au/Global/Publications/For%20disability%20service%20providers/Guidelines%20and%20policies/Behaviour%20Support/Sector-Update-Positive-Behaviour-Framework-November-2014.pdf> (accessed 23 October 2015).

67 Queensland Government Department of Communities, Child Safety and Disability Services, *Overview of amendments*, 19 March 2015, <https://www.communities.qld.gov.au/disability/key-projects/disability-services-act-2006/review-of-restrictive-practices-framework/overview-of-amendments> (accessed 23 October 2015).

4.82 Many of the decisions about the use restrictive practices must be approved or reviewed by the Queensland Civil and Administrative Tribunal, and in addition the Queensland Department of Communities, Child Safety and Disability Services has established the Centre of Excellence for Behaviour Support, to provide training and guidance on positive behaviour support techniques.

4.83 The committee notes its concern that the requirement for service providers to have their own restrictive practices policies has been removed from the legislation and the legislation only applies to adults.⁶⁸

Victoria

4.84 The introduction of the *Mental Health Act 2014* has led to a number of changes in how restrictive practice is used in mental health services under the previous *Mental Health Act 1986*. First, the Mental Health Act's objectives have been extended to ensure people with a mental illness are provided with care and treatment with the 'least possible restrictions on human rights and human dignity'.⁶⁹ Second, this Act also defines when a restrictive intervention may be used and who must be notified when a restrictive intervention occurs.⁷⁰

4.85 Within the Victorian Department of Health and Human Services sits the Office of Professional Practice. One of the officers within the Office of Professional Practice is the Senior Practitioner (Disability). Under section 23(2)(a) of the *Disability Act 2006*, the 'Senior Practitioner is responsible for ensuring the rights of persons who are subject to restrictive interventions and compulsory treatment are protected and that appropriate standards in relation to restrictive interventions and compulsory treatment are complied with'. Aspects of the Senior Practitioner's role are highlighted below:

- visit, talk to and inspect any disability service;
- see any person who is subject to any restrictive intervention or compulsory treatment;
- investigate, audit and monitor the use of any restrictive interventions or compulsory treatment;
- direct a disability service provider to discontinue a restrictive practice;
- evaluate and monitor the use of restrictive interventions in disability services;
- develop guidelines and standards; and

68 Queensland Government Department of Communities, Child Safety and Disability Services, *Overview of amendments*, 19 March 2015, <https://www.communities.qld.gov.au/disability/key-projects/disability-services-act-2006/review-of-restrictive-practices-framework/overview-of-amendments> (accessed 23 October 2015).

69 *Mental Health Act 2014*, s. 10(b). See also: *Mental Health Act 1986*, s.4(2)(a).

70 *Mental Health Act 2014*, s. 105–116.

- provide education and information to disability service providers.⁷¹

Australian Capital Territory

4.86 Although there is a reference in the objects of the *Mental Health (Treatment and Care) Act 1994* 'to ensure that mentally dysfunctional or mentally ill persons have the right to receive treatment, care, rehabilitation and protection in an environment that is the least restrictive and intrusive, having regard to their needs and the need to protect other persons from physical and emotional harm', the use of restrictive practices are not regulated in the ACT.⁷² An examination of the use of restrictive practices in ACT schools is conducted later in this chapter.

South Australia

4.87 Restrictive practices are not regulated in South Australia. In 2011, the Office of the Public Advocate released a voluntary policy to prevent and eliminate restrictive practices in the disability sector for use by guardians and advocates. In March of this year, a similar policy was released for the residential aged care sector.⁷³

Tasmania

4.88 In Tasmania, restrictive practices in the health and disability services sectors are regulated by the Senior Practitioner (SP) who must be informed when a restrictive practice is used. The SP has powers to investigate instances where restrictive practice is alleged to have been used and can make recommendations and even directions to a provider to use alternate options. The SP is empowered to apply financial penalties to any provider who does not reasonably follow the directives of the SP.⁷⁴

Northern Territory

4.89 The Northern Territory regulates the use of restrictive practices in the mental health and disability services sector through section 61 and 62 of the *Mental Health and Related Services Act 1994*. This legislation works from the principle that restrictive practices are only to be used when no other option is available and only with the approval of a psychiatrist or a registered senior nurse. It is an unlawful act for any other person to apply restrictive practices to any other person subject to a penalty.⁷⁵ The *Disability Services Act 2012* also makes it an offence to use restrictive intervention on a resident of a residential facility.⁷⁶

71 Victorian Department of Health and Human Services, *Office of Professional Practice*, 29 July 2015, <http://www.dhs.vic.gov.au/about-the-department/our-organisation/organisational-structure/our-groups/office-of-professional-practice> (accessed 23 October 2015).

72 *Mental Health (Treatment and Care) Act 1994*, s. 7(a).

73 South Australian Office of the Public Advocate, *Restrictive Practices*, http://www.opa.sa.gov.au/resources/restrictive_practices (accessed 23 October 2015).

74 Tasmanian Department of Health and Human Services, *Senior Practitioner*, http://www.dhhs.tas.gov.au/disability/senior_practitioner (accessed 23 October 2015).

75 *Mental Health (Treatment and Care) Act 1994*, s. 61–62.

76 *Disability Services Act 2012*, s. 41.

4.90 In NSW, guidelines govern the use of restrictive practices. For NSW declared mental health units, a NSW Health guideline states the use of physical restraint should be an option of last resort and outlines when forms of restraint may be suitable. The restraint team must include a senior nurse or medical officer and the primary carer must be notified after an incident of restraint.⁷⁷ The NSW Department of Family and Community Services, *Behaviour Support Policy*, outlines requirements for the use of restrictive practice in NSW government funded disability services. The policy states 'Ideally, behaviour support services should be provided by *Behaviour Support Practitioners* with tertiary qualifications', although this is not a mandatory requirement.⁷⁸ Guardians appointed under the *Guardianship Act 1987* (NSW) may be authorised to consent to the use of restrictive practices for people over 16 years of age.

4.91 Restrictive practices in relation to children are governed by *Children and Young Persons (Care and Protection) Act 1998* (NSW) and *Children and Young Persons (Care and Protection) Regulation 2012* (NSW).⁷⁹ A broader examination of the use of restrictive practice in NSW is considered later in this chapter, by providing a comparison between the highly regulated use of restrictive practice in a disability service context to the largely unregulated and unmonitored use of restrictive practice against children with disability in NSW schools.

77 NSW Department of Health, *Aggression, Seclusion & Restraint in Mental Health Facilities in NSW*, http://www0.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_035.pdf (accessed 4 November 2015)

78 NSW Department of Family and Community Services, *Behaviour Support Policy*, https://www.adhc.nsw.gov.au/_data/assets/file/0007/228364/Behaviour_Support_Policy_Marc_h2012_updated.pdf (accessed 4 November 2015)

Committee view

4.92 The committee considers that the right to liberty is a fundamental human right. The committee is concerned with the extent to which restrictive practice is used, and is deeply concerned with the system which allows service providers to arbitrarily deprive people of their liberty.

4.93 The Committee acknowledges the development of the *National Framework for Reducing and Eliminating the use of Restrictive Practices in the Disability Service Sector*. However, the committee is concerned that this implementation of this framework has stalled, and has not been consistently implemented across Australian jurisdictions, with many states and territories still relying on a voluntary code of conduct from disability service providers.

4.94 The committee notes that the implementation of the framework has stalled, and in some jurisdictions has never really begun. The committee sees a place for commonwealth legislation, should the framework not be vigorously taken up across all jurisdictions as a priority.

Restrictive practices in other settings

4.95 The committee notes that restrictive practices may also be used in institutions and residential settings outside of the disability services sector.

4.96 The committee is particularly concerned by evidence that suggests that the regulations and safeguards for restrictive practices required in the disability sector do not apply in the prison system. The Aboriginal Disability Justice Campaign recommended that correctional services in all jurisdictions adopt the *National Framework for Reducing and Eliminating the use of Restrictive Practices in the Disability Service Sector*, particularly:

- independent advocacy services for people with cognitive impairments detained in prisons and subject to restrictive practices; and
- independent review and oversight of restrictive practices used in prisons.⁸⁰

4.97 Box 4.1 highlights the lack of regulation and oversight of restrictive practices for Aboriginal and Torres Strait Islander peoples with cognitive impairment in prisons in the Northern Territory and Western Australia.

80 Aboriginal Disability Justice Campaign, *Submission 159*, p. 6.

Box 4.1: Restrictive practices in prisons

The Aboriginal Disability Justice Campaign (ADJC) alleged that chemical, physical and mechanical restraints are used extensively on people with cognitive impairment in prisons in Western Australia and the Northern Territory. The ADJC estimated that approximately 150 people with cognitive impairment are detained in prisons on civil orders each year, of which approximately 30 are Aboriginal or Torres Strait Islander and 30 are 'detained indefinitely'.

The ADJC noted that unlike the disability sector, where restrictive practices are regulated by legislation consistent with Australia's international human rights obligations:

[t]here is no reference to these principles, safeguards or human rights obligations in the use of restraint and seclusion on people with cognitive impairments detained under Corrective Services legislation in either Western Australia or the Northern Territory.

The ADJC highlighted that the lack of regulation on restrictive practices in prisons means that people with a cognitive impairment detained in prison 'are at a disadvantage to those who would be subject to restrictive interventions in forensic disability setting in terms of process, safeguards, review mechanisms and access to advocacy and oversight'.

The ADJC provided two case study examples that demonstrate the unregulated use of restrictive practices on people with cognitive impairment.

Mr M – Northern Territory

Mr M is an Aboriginal man with severe intellectual disability and foetal alcohol spectrum disorder who has been detained in a Northern Territory correctional facility since 2007. According to the ADJC, the facility has used a number of restraints in response to Mr M's 'behaviours of concern', including 'being forcibly removed from his cell by correctional staff, belted into a restraint chair and injected with a tranquiliser until he was sedated' for between 30 minutes and two hours at a time. The ADJC alleged that between 2012 and 2013, this restraint has been used between 13 and 15 times, despite the Office of the Public Guardian and the Office of Disability refusing to consent to or support the intervention. The ADJC further alleged that over this period, Mr M was 'chemically restrained by the use of PRN medication that is prescribed by a forensic mental health psychiatrist 40 out of the 52 weeks of the year'.

Ms F – Western Australia/Northern Territory

Ms F is an Aboriginal woman with foetal alcohol spectrum disorder from Alice Springs who was detained for twenty months in a Western Australian correction facility for traffic offences after being found unfit to plead. Ms F was returned to the Northern Territory in June 2014 following intervention from the ADJC and has since been detained four times for various offences. The ADJC alleged that during the last period of detention, Ms F was restrained and placed in solitary confinement after being extremely agitated following a meeting with the Office of the Public Guardian where she was given inaccurate advice about the date of her release. The ADJC noted that the facility has refused to confirm how long Ms F was held in solitary confinement.

Source: Aboriginal Disability Justice Campaign, *Submission 159*, pp 1–6.

Committee view

4.98 The committee is deeply concerned that people with cognitive impairment and intellectual disability in the prison system are not subject to the same protections and safeguards regarding restrictive practice as those in the disability services sector. This highlights the inappropriateness of detaining people with disability in facilities which are not specifically for the purpose of delivery of therapeutic services.

4.99 The committee considers that the principles of the *National Framework for Reducing and Eliminating the use of Restrictive Practices in the Disability Service Sector* should apply to all institutions where people with disability are accommodated, particularly prisons.

Restrictive practices in schools

4.100 Currently there is a wide range of restrictive practices used in schools, ostensibly for student discipline. Evidence to the committee indicates the conflation of disability and behaviour management within the school environment often results in the adhoc and non-consensual use of restrictive practices such as exclusion, seclusion and restraint. The Law Reform Commission explains:

Restrictive practices involve the use of interventions and practices that have the effect of restricting the rights or freedom of movement of a person with disability. These primarily include restraint (chemical, mechanical, social or physical) and seclusion. People with disability who display 'challenging behaviour' or 'behaviours of concern' may be subjected to restrictive practices in a variety of contexts, including: supported accommodation and group homes; residential aged care facilities; mental health facilities; hospitals; prisons; and schools.⁸¹

4.101 A recent case in the ACT involving a ten-year old boy diagnosed with autism being placed in a cage as a 'withdrawal space' has highlighted these practices as being out of step with community values and expectations if used inappropriately.⁸² This case raises questions as to the adequacy of frameworks at a federal, state and territory level that guide and inform schools—teachers and principals—on acceptable use of restrictive practices. This case study is examined below in Box 4.2.

81 Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws (DP 81): Restrictive Practices*, <http://www.alrc.gov.au/publications/8-restrictive-practices/restrictive-practices-australia> (accessed 17 August 2015).

82 Matthew Doran, 'Use of cage for boy with autism at Canberra school prompts call for national education standard', *ABC News Online*, 3 April 2015, <http://www.abc.net.au/news/2015-04-03/experts-slam-need-to-cage-boy-wth-autism-at-canberra-school/6369470> (accessed 17 August 2015).

Box 4.2: School child restrained in cage at an ACT school

In April 2015, it was reported that a ten year old child with autism had been placed in a purpose built cage structure in an ACT primary school as a means of managing the behaviour of the child. This withdrawal space had been constructed to provide an area for the child to 'calm down' in. An investigation found that the space was visible from the classroom and had been described to fellow classmates and the child as a 'sanctuary'. Responsibility for the incident was attributed solely to the school's principal.

Although the investigation was keen to highlight the 'high expectations on all teachers, principals and officers of the directorate [ACT Directorate of Education and Training]', and that 'specialist expertise' is available for the teachers and principals to access, it also found that:

- Officers within the Directorate may not have provided adequate support to manage the escalating circumstances within the school.
- The first officers to be notified of the structure did not act on this advice and referred the complainant to another part of the Directorate. There is no record of a further contact from the complainant.
- Officers within the Directorate did not meet Directorate or public expectations by acting with sufficient urgency or alarm when provided with information about the structure.

The investigation's public report did not detail the existence or adequacy of directorate policy or practice for school children with disability—despite this being included in the investigation's scope. Despite the directorate seeking to attribute all of the blame to the principal, the directorate's first response as outlined above demonstrates a lack of support from the directorate to the school on these issues. The report also failed to examine the school and the directorate's response and interactions with the child, the family and the broader school community during the aftermath until five months after the incident had been brought to the attention of the directorate.

In May 2015 the ACT Government established an Expert Panel on Students with Complex Needs and Challenging Behaviour to review policies and procedures. The Expert Panel's report, released on 18 November 2015, made a series of recommendations to reform the ACT school system including an urgent review of funding for students with special needs, training for teachers and aides and greater support for principals.

Sources: Emma Macdonald and Georgina Connery, 'Child reportedly contained in cage-like structure at ACT primary school, *The Canberra Times*, 3 April 2015, <http://www.canberratimes.com.au/act-news/child-reportedly-contained-in-cagelike-structure-at-act-primary-school-20150402-1mdj0b.html> (accessed 18 September 2015).

ACT Directorate of Education and Training, *Investigation into an Inappropriate Structure Report Handout*, http://www.det.act.gov.au/_data/assets/pdf_file/0006/770208/150908-Inappropriate-Structure-Handout.pdf (accessed 18 September 2015).

ACT Directorate of Education and Training, *Expert Panel: Students with Complex Needs and Challenging Behaviour*, http://www.det.act.gov.au/school_education/complex-needs (accessed 19 November 2015).

4.102 The ACT example is not an isolated case. During the course of this inquiry, the Victorian Government has implemented a review into restrictive practices at two schools for people with disability—Monash Special Development School (SDS) and Bendigo SDS. This investigation will examine allegations of restraining children with straps and locking children in cupboards and cages.⁸³

4.103 In her submission, Ms Julie Phillips describes the 'variety of spaces [used] to seclude children with disabilities, including a locked cupboard, a disused school room used for junk, outdoor pens, and designated seclusion rooms'. Other spaces, such as 'outdoor pens, similar to those used to keep cattle or sheep in a small area are employed'. The worst example is the 'Safe Room' found at the Bendigo SDS 'which is approximately the size of a disabled toilet, has wooden walls which cannot be seen through, and two bolts for locking on the outside'.⁸⁴ A recent image of what is termed a 'Safe Room' can be seen below in image 4.1, whilst a purpose built enclosure visible to fellow classmates from the playground can be seen below in image 4.2.

83 Henrietta Cook, 'Allegations of students in cage-like structures triggers investigation', *The Age*, 22 September 2015, <http://www.theage.com.au/victoria/allegations-of-students-in-cagelike-structures-triggers-investigation-20150921-gjrnd8.html> (accessed 23 September 2015). See also: Richard Baines, 'Claims 11yo girl with autism left isolated, unsupervised at Tasmanian school', *ABC News Online*, 27 September 2015, <http://www.abc.net.au/news/2015-09-26/claims-autistic-child-left-unsupervised-at-tasmanian-school/6807292> (accessed 29 September 2015).

84 Ms Julie Phillips, *Submission 131*, p. 11. See also: Victorian Equal Opportunity and Human Rights Commission, *Held back: The experiences of students with disabilities in Victorian schools*, September 2012, <http://www.humanrightscommission.vic.gov.au/index.php/our-resources-and-publications/reports/item/184-held-back-the-experiences-of-students-with-disabilities-in-victorian-schools-sep-2012> (accessed 21 September 2015). See also: *Submission 131b*, *Submission 131c*, *Submission 131e*.

Image 4.1: A "safe room" in use at a Victorian public school at time of submission to inquiry



Source: Ms Julie Phillips, Submission 131c.

Image 4.2: A fenced seclusion area visible from the school playground



Source: Ms Julie Phillips, Submission 131c.

4.104 The committee has received evidence from Children with Disability which describes examples of restrictive practices on children in schools and the impact this has had on them. Some of these examples are described in Box 4.3.

Box 4.3: Lived experience of restrictive practices on children and young people with disability in the Australian education system

(I only) recently stopped my son's special school using a time out chair in a separate room - (the) chair (was) bolted to the floor and my son belted in – Parent.

The school I went to would (hold) down students for not doing their work. Surely there are better strategies than that – Student.

(My son) was 18 months old when he was excluded from day care. They had no interest at all in assisting him. I only found out after leaving from a staff member, that he was left restrained in a high chair for long periods of time – Parent.

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

My son was tied down with rope to a chair...while in childcare because he wouldn't sit and listen to story time – Parent.

As an acceptable strategy to safeguard a student from hitting his head, school personnel tied a student to his chair for all class lessons and then tied him to a pillow on the floor during other activities – Parent.

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

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

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

My son had a 'containment area' built for him when he was in Prep... horrific! – Parent.

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

Source: Children with Disability, Submission 144.

4.105 An example of a behaviour management plan from a Victorian school was provided to the committee. This pro-forma document has a number of key sections relating to behaviour management left blank, including the student's communication preference/receptive language, interests, and behaviour triggers. A disturbing instruction can be found written under 'Strategies to eliminate or mitigate the risk':

If all else fails, give [Name withheld] a choice between doing X or going to the 'safe room' [Name withheld] will usually respond. **Make him verbalise what he will do.**

If [Name withheld's] behaviour deteriorates and he doesn't respond, there's no point talking, just get him to the 'safe room' for time out. 2 [sic] able staff are required to escort him to the 'safe room'.⁸⁵

4.106 At the Sydney public hearing, Julie Phillips described 'restrictive practices' as:

I do not like the term 'restrictive practices', because it is a euphemism for what is often simply assault, false imprisonment and abuse. On occasion they are restrictive practices. But I feel very strongly about restraint and seclusion being used when they are not a last resort, and most of the time—despite the policies and procedures saying they can only be used as a last resort—they are not. In fact, out of all the cases that I have worked with I have never seen any restrictive practices used as a last resort.⁸⁶

4.107 Ms Therese Sands of Disability Alliance shared her thought on 'restrictive practice' policy in the educational context:

I think [restrictive practice] is particularly prevalent in schools, whereas in many other systems there is either some form of regulation or maybe an attempt at regulation in policies and procedures—maybe there are senior practitioners et cetera. In the school system there is absolutely no oversight or regulation, and often it is up to school principals, the schoolteacher and specific approaches and cultures within schools.⁸⁷

4.108 At a broad level, the absence of policy and guidance from state and territory education departments perpetuate this cycle of abuse. In some cases, principals and teachers working at the coal-face do not know how to manage behaviours of concern (a combination of lack of training and experience); and even if they do, there is insufficient funding to put in place positive behaviour change programs:

In terms of the schools, the policies and procedures around the country are very similar in that they are vague and broad and are open to interpretation—so open they are fairly meaningless. I have picked some out. New South Wales, for example, says that you cannot use physical restraint if there is a risk of injury to staff, but you can use physical restraint on a child for a threat to departmental property. In Queensland they can put physical restraint into a student's individual plan. That is not at all

85 Ms Julie Phillips, *Submission 131f*.

86 Ms Julie Phillips, *Committee Hansard*, Sydney, 27 August 2015, p. 54.

87 Ms Therese Sands, Co-Chief Executive Officer, People with Disability Australia; Australian Cross Disability Alliance, *Committee Hansard*, Sydney, 27 August 2015, p. 38.

acceptable in any sort of disability service, because it means you are intending to use it repeatedly and that is not the way that physical restraint is meant to be used. Western Australia is similar except that you can use restraint to maintain order or re-establish order. Anyone could say that they were maintaining order to excuse the fact that they had used such practices. Such practices are also used in regard to property damage.

What is missing in all of these policies and procedures and sometimes in educational regulations is compulsory training, comprehensive behaviour assessments—which Dr Anderson can talk more about—positive behaviour plans, any intensive psychological support that might be required, any evidence based approach to the problems that have arisen and proactive approaches. All of these policies and procedures are about reacting to challenging behaviours.⁸⁸

4.109 It is not clear to the committee whether any of the state and territory education departments have any fully developed enforceable policy guidance on restrictive practices. While the Restrictive Practice Framework applies to most disability services and agencies, there is a notable absence of regulation of restrictive practice used on children and young adults with disability in schools or other educational facilities.⁸⁹

4.110 During the course of this inquiry, the Victorian Government announced the appointment of a Principal Practice Leader (Education). This position reports to the Senior Practitioner (Disability) within the Office of Professional Practice (Department of Health and Human Services). The Principal Practice Leader (Education) will:

[V]isit and work with government schools throughout Victoria to gain an understanding of current processes and staff knowledge and provide advice related to best practice approaches and processes for supporting and responding to students with challenging behaviours, including least restrictive practices.

The Principal Practice Leader will work with the Department to identify improvements that could be made to professional learning and training, and current legislation, policies and guidelines under the direction and guidance of the Senior Practitioner (Disability).⁹⁰

4.111 Some submitters were not convinced that the Principal Practice Leader (Education) will be the panacea to many of the problems experienced within the education system. Ms Julie Phillips notes that without legislative amendments that transfer the regulation of restrictive practices in Victorian schools to the Office of the Senior Practitioner within the Department of Health and Human Services, the appointment is 'akin to a project worker gathering information and providing advice'.⁹¹

88 Ms Julie Phillips, *Committee Hansard*, Sydney, 27 August 2015, p. 54.

89 This is also noted by Ms Julie Phillips in evidence at the Sydney hearing.

90 Victorian Department of Education and Training, *Principal Practice Leader (Education)*, 3 September 2015, <http://www.education.vic.gov.au/about/departments/Pages/seniorpractitioner.aspx> (accessed 30 September 2015).

91 Ms Julie Phillips, *Submission 131ss*, pp 3–4.

4.112 The Victorian Government has also announced a new 'Restraint of Student' policy which describes when restrictive practices such as restraint and seclusion practices may be used. This policy notes that physical restraint and seclusion may only be used 'when it is immediately required to protect the safety of the student or any other person'.⁹² Importantly, these policies contain a range of compulsory actions that must be undertaken in the event that restrictive practices are utilised. These include immediately reporting the incident to the school principal and a student's parents or guardians. A range of supports must be provided to the student and their parents or guardians. A detailed written record with prescribed information must be completed and uploaded to the Education department's administrative system.⁹³

4.113 The committee acknowledges the Victorian Government's first steps towards reform in this difficult area, but notes a number of concerns with the initial approach taken. Ostensibly, restrictive practices are ruled out, however, it is not clear what type of strategies—funding and support—will be provided in its stead.

New South Wales—a case study

4.114 A key issue raised by witnesses to the inquiry, is the gap in the regulatory frameworks on restrictive practice, which prohibits or regulates certain practices in one service setting, while allowing it in another service setting.

4.115 The following section has taken the jurisdiction of NSW as a sample study, to highlight how restrictive practice is regulated within the NSW education system as compared to the policy framework in other NSW state government departments and agencies. It is worth noting that the regulation of restrictive practices in NSW schools does not appear to have the same level of rigorous regulation. In some cases, schools may be using 'seclusion' as a time out technique, which is banned for children in other service provider contexts.

92 Seclusion is 'the involuntary confinement of a student alone in a room or area which the student is physically prevented from leaving'. The policy notes that seclusion is different to the concept of timeout which is a separate behavioural management tool.

93 Victorian Department of Education and Training, *School Policy and Advisory Guide: Restraint of Student*, 6 October 2015, <http://www.education.vic.gov.au/school/principals/spag/governance/pages/restraint.aspx> (accessed 12 October 2015).

Box 4.4: New South Wales—a case study

In NSW, each school must prepare a discipline policy which outlines 'how discipline is implemented in the school...to inform and guide students, staff and parents about the aims, underlying philosophy, strategies and responsibilities for student discipline'. This policy must be reviewed every three years. The NSW Department of Education and Training (NSW DET) provides a range of policy guidance and support materials including that a discipline policy must be consistent with the *Disability Discrimination Act 1992* and the *Disability Standards for Education 2005*.¹

However, in many of these documents, there is no detailed discussion of children with disability. This approach appears to then flow into the discipline policies themselves with a number of current discipline policies for NSW public schools available online.¹ In most of the policies viewed, people with disability were not mentioned.

There are a range of NSW government documents that are used to provide guidance around restraint and seclusion of minors with disability.

Guidelines for the Use of Time-out Strategies including Dedicated Time-out Rooms

The NSW DET provides guidelines on the use of time-out as part of a broader disciplinary strategy. The NSW DET explains:

*Time-out strategies are included by some schools in their school discipline policies for use when a student is behaving inappropriately and temporary separation from that particular environment may assist in supporting the student to demonstrate appropriate behaviour.*¹

Although this document is quite comprehensive—outlining when time-out is suitable and how it should be approached, communicated and documented—it only addresses the issue of children with disability once:

*A small number of students who have very complex needs may require specific, personalised learning and support when more general time-out procedures are not appropriate. These interventions, including any on-going use of a dedicated time-out room, may only be implemented if developed, monitored and reviewed by a case management team, consented to by the parents and approved by the principal. The case management team may include the student, parents or carers, school and local Department of Education staff, health professionals and staff from other agencies or government departments.*¹

*Sources: NSW Department of Education and Communities, *Student Discipline in Government Schools: Support Materials*, 2006; Lambton High School Welfare Discipline Policy; NSW Department of Education and Communities, *Guidelines for the Use of Time-out Strategies Including Dedicated Time-out Rooms*, 2011.*

4.116 In contrast, it is interesting to compare the regulatory environment that governs other NSW government departments. The NSW Department of Health guidance note, *Aggression, Seclusion and Restraint in Mental Health Facilities in NSW*, relates to mental health facilities. There a number of principles for those aged under 18 years of age that are transferable to the education domain:

The consumer's primary carer (as defined by NSW Mental Health Act 2007, Section 71) will be informed of any incident involving restraint/seclusion as soon as is reasonably possible after the event. They

will be told the reason why this intervention was used, the period of time it was applied and any consequences of the intervention...

Family/carers of children and young people (under 18 years) involved in episodes of seclusion or restraint should be contacted as soon as possible regardless of the time of the event...

For anyone under 18 years of age, the parents or guardian will be notified unless there are particular reasons this would be not in the child or young person's best interests.⁹⁴

4.117 This guidance note is also quite explicit in describing all of the requirements of an individual who is deemed to require restraint. This level of detail is absent from all educational policy directives.

4.118 Another document that contains a number of useful principles in this area is the former NSW Department of Family and Community Services *Behaviour Support: Policy and Practice Manual*.⁹⁵

4.119 This manual was developed by the Office of the Senior Practitioner, which was established to provide guidance on behaviour support and intervention services delivered by NSW funded ageing, disability and homecare services. The manual:

has been designed to provide a contemporary, practical resource for the development of high quality and consistent support and intervention practices which adhere to relevant departmental policy and procedures and legislative standards...

is targeted to assist Behaviour Support Practitioners drawn from a range of professional backgrounds and who undertake their work in diverse contexts. It will assist them to interact in inclusive, consultative and collaborative ways through the use of accessible, evidence-based support formats and practice approaches...

Importantly, the manual provides guidelines to safeguard the rights of the individual Service User and promotes the use of person-centred positive behaviour support practices. It recognises that all behaviour occurs within a context and that meaningful, longitudinal behaviour change relies not only on maintenance of appropriate supports for the Service User, but also on refinement of the wider support system built around the individual.⁹⁶

94 NSW Department of Health, *Policy Directive: Aggression, Seclusion and Restraint in Mental Health facilities in NSW*, June 2012, http://www0.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_035.pdf (accessed 2 October 2015).

95 NSW Department of Family and Community Services, *Behaviour Support: Policy and Practice Manual. Guidelines for the provision of behaviour support services for people with an intellectual disability. Part 1: Policy and Practice*, January 2009. https://www.adhc.nsw.gov.au/_data/assets/file/0003/228360/341_Behaviour_Support_Policy_and_Practice_Manual_Part_1_web.pdf (accessed 2 October 2015).

96 NSW Department of Family and Community Services, *Behaviour Support: Policy and Practice Manual. Guidelines for the provision of behaviour support services for people with an intellectual disability. Part 1: Policy and Practice*, January 2009.

4.120 Importantly, this policy applies to adults, children and young people with intellectual disabilities and spells out how restricted practices are to be employed on children and young people.¹

4.121 There are a number of standards that this policy complies with including:

- NSW Out-of-Home Care Standards (NSW Office of the Children's Guardian);
- Living in the Community: Putting Children First (July 2002);
- The Children's Standards in Action (2004);
- Individual Planning for Children and Young People Living in Out-of-Home Placements: Policy and Procedures (May 2007);
- Memorandum of Understanding between the Department of Community Services and the NSW Department of Ageing, Disability and Home Care on Children and Young Persons with a Disability, and;
- NSW Interagency Guidelines for Child Protection Intervention (DoCS 2006).⁹⁷

4.122 The manual is intended to be implemented in conjunction with the Behaviour Support Policy, last updated in March 2012. The two policy documents outline that restrictive practices, except in exceptional emergencies, should be used only in the context of a Behaviour Support Plan developed by a behaviour support specialist. The policy explicitly differentiates between Exclusionary Time Out and Seclusion. Exclusionary Time Out removes a person from one setting to another for a period of time under supervision. It must be part of an overall planned strategy, time-limited, contingent on behaviour change and must be supervised at all times. Seclusion is the isolation of a person in a setting by themselves and must be monitored at all times. Seclusion in a disability service setting is banned for anyone under 18 years of age under all circumstances.

Transparency and behaviour modification

4.123 On another level, parents of children with disability have very limited rights to be involved in how their children are taught and treated at school. One submitter notes that parents 'do not have the right to':

- refuse restrictive practices;
- be told about restrictive practices used on their child in schools;
- attend Student Support Group meetings;
- agree with or have input into Individual Education Plans;
- agree with or have input into a Behaviour Plan;

97 NSW Department of Family and Community Services, *Behaviour Support: Policy and Practice Manual. Guidelines for the provision of behaviour support services for people with an intellectual disability. Part 1: Policy and Practice*, January 2009.

- request the intervention of psychologists or other experts who have the ability to address challenging behaviours;
- insist that their child has a formal language assessment;
- insist that their child has a formal communication method and that staff must be trained in that method;
- insist that staffing levels must be adequate to support their child;
- in some schools, enter the school buildings; and
- insist that their child has assistance from anyone with a particular qualification or training (for example integration aides are commonly hired in response to individual funding received, and such aides require no qualifications regardless of how complex the child's disabilities are).⁹⁸

4.124 Ultimately, 'restrictive practices' punish certain types of behaviour rather than rewarding or encouraging positive behaviour. The committee heard that often, 'bad' behaviour is actually a response to the environment and support (or lack thereof) that a child is provided with at school. Dr Angelika Anderson explained the complex link between disability, environment and challenging behaviours:

Children with disabilities, or individuals with disabilities, are at risk for developing behaviours of concern because they often have skill deficits, especially those individuals who have impairments in social communication. They are not able to signal their needs and wants, and often challenging behaviour has a communicative function. That finally is the only thing that works for them. That means that automatically children with autism, but also other populations, such as migrant populations for whom English is a second language or who do not have the same cultural background or have not been brought up with and are not very familiar with the behavioural expectations in schools, are at higher risk.⁹⁹

4.125 The Disability Alliance agreed and went further, stating that 'these behaviours can be viewed as a form of resistance or protest to maladaptive environments; and should be viewed as legitimate responses to problematic environments and situations. Changing services, systems and environments should be the starting point for changing behaviour, rather than changing the person'.¹⁰⁰

4.126 The Disability Alliance also noted the role that 'restrictive behaviours' play in enabling and normalising other forms of violence, by 'desensitising both staff and people with disability, undermining their ability to recognise violence, to view it as unacceptable and respond to it as a crime'.

4.127 Families Australia noted that 'policies and safeguards to protect children and young people in respite, at school and being transported to and from school are

98 Communication Rights Australia, *Submission 78*, p. 10.

99 Dr Angelika Anderson, *Committee Hansard*, Sydney, 17 August 2015, p. 59.

100 Australian Cross Disability Alliance, *Submission 147*, pp 45–46.

critical.¹⁰¹ In its submission, the LCA highlighted a report on the experiences of children with disabilities in Victorian schools which found:

In many of these cases appropriate understanding of triggers of behaviour and the best ways to de-escalate a child experiencing heightened behaviours, by adequately trained staff, would vastly reduce the need for use of seclusion and restraint techniques...

Improved policies and procedures in this area, and supervision and implementation of them are urgently required. Appropriate recruitment, training and a change in culture of many schools would dramatically reduce the need for these strategies to be used.¹⁰²

4.128 The Law Reform Commission in its Final Report entitled *Equality, Capacity and Disability in Commonwealth Laws* made the following recommendation in relation to restrictive practices:

The Australian Government and the Council of Australian Governments should develop a national approach to the regulation of restrictive practices in sectors other than disability services, such as aged care and health care.¹⁰³

4.129 A major concern to the committee is that educational opportunities and outcomes for children with disability are lost as a result of these practices.¹⁰⁴ The need to encourage and support all Australian children to participate in their education in a meaningful way highlights the critical importance of support rather than punitive measures. As one submitter noted:

The effect [of restrictive practices] on the children is obvious to any observer. The children themselves have become worse in their behaviour. While doing the [Applied Behavioural Analysis] ABA behaviour therapy with me they were in a support unit in a general public school and had never been sent home. While their behaviour needed addressing they were capable of handling small incidents. The first time [Name withheld] was too uncontrollable and sent home from school was only weeks after the JIRT [Joint Investigation Response Team] involvement as they refused to address the risk issues I was pointing out to them. Now no public school in the area will accept the children and they are forced to go to a special school. [Name withheld] missed out on full time schooling for months while waiting for a place...

What is worse is the children's behaviours and health have also deteriorated. [Name withheld] is overweight as we have not been able to

101 Families Australia, *Submission 3*, p. [3].

102 Law Council of Australia, *Submission 139*, p. 7.

103 Recommendation 8–2 in Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws: Final Report*, Law Reform Commission Report 124, August 2014, p. 19, https://www.alrc.gov.au/sites/default/files/pdfs/publications/alrc_124_whole_pdf_file.pdf (accessed 23 September 2015).

104 Youth Disability Advocacy Service, *Submission 88*.

concentrate on his welfare with the Systems Abuse that occurred. [Name withheld] behaviour has declined and he is now self-harming (biting himself) and pulls at others. There (sic) behaviour has become so bad that I cannot take them to the activities I used to attend.¹⁰⁵

Committee view (restrictive practice in education)

4.130 The committee notes the previously described examples clearly do not meet community expectations and standards when it comes to how children—abled or with disability—are treated at an Australian school in 2015, which begs the question—why does it still happen?

4.131 The committee is greatly concerned with what appears to be systemic problems within the education system that are leading to many of the inappropriate practices described in this section. Many of the systemic problems that lead to the use of restrictive practices actually reinforce an attitude that facilitates the mistreatment of children with disability because they are viewed as different.

4.132 The committee notes that the Queensland Department of Education has a Standard Operating Procedure for the treatment and use of horses and ponies in schools, but no policy for the use of restrictive practices on Queensland schoolchildren.

4.133 There needs to be a national approach with regard to regulation. It is not clear to the committee why the education system sits aside from the standards expected of other mainstream services such as health and disability services that support people with disability.

4.134 It is the committee's strong view that the *National Framework for Reducing and Eliminating the use of Restrictive Practices in the Disability Service Sector* should be extended and apply to educational facilities. It is also the committee's view that states and territories need to establish and implement enforceable policies and guidance for school teachers and principals that eliminates the use of 'restrictive practices'.

4.135 It is also deeply concerning that not only are parents not allowed to refuse the use of 'restrictive practices' or be involved in the decision-making process, but they are not even made aware of the use of such policies. It is the committee's view that transparency around these processes is the first step in moving to eliminate the use of restrictive practices against children..

4.136 It is the committee's view that proven positive behavioural management tools such as Applied Behavioural Analysis need to take the place of restrictive practices and need to be properly funded and professionally supported.

105 Mr Michael Hart, *Submission 79*, p. 23. See also: Autism Behavioural Intervention Association, http://www.abia.net.au/applied_behavioural_analysis (accessed 16 September 2015). The Association notes that 'research has shown that at least 15–20 hours of intensive therapy per week is needed to produce long-term benefits'.

Concluding committee view

4.137 One of the main areas of concern for the committee relates to the black and white approach to legal incapacity. As the law currently stands, if a person is deemed to lack legal capacity, then a legal guardian becomes a substitute decision-maker. The committee supports a move towards supported decision-making as being more appropriate in many circumstances, and considers it is time to curtail the use of substitute decision-making..

4.138 The committee agrees with the premise that the concept of legal incapacity is more subtle and complex than the current absolutist approach. The committee sees that legislative reform is required to accommodate a spectrum of decision-making, to ensure that where a person requires support to make certain decisions, such as substantial financial decisions, they do not lose the right to make *all* decisions, such as where they live or who may visit them.

4.139 The committee notes the volume of evidence which shows that no single jurisdiction has created a guardianship system that is either free of abuse or neglect, or has appropriate oversight to ascertain that abuse or neglect is not occurring at far higher rates than is currently known. Clearly a national project to establish best-practice across the states and territories is of critical need.

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

4.141 The committee was distressed to be presented with all too many harrowing accounts of small children suffering at the hands of the very people who should be educating them. It is hard to understand how strapping a child to furniture, or locking them alone in a room to scream themselves into exhaustion could be seen as a justifiable behavioural intervention. This is without doubt a national shame.

4.142 As a matter of urgency, the Restrictive Practice Framework must be implemented as an enforceable, reviewable instrument for all schools, government and private, and there must be independent oversight of its implementation in schools.

