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

Overview of responses to the **Restrictive practices Issues paper**

April 2021

Please be aware that the content in this overview may be distressing or raise issues of concern for some readers.

There are a range of services available if you require support after reading this paper. Contact details for these services are located at the end of this paper under the heading ‘Support’.

Outline

The Restrictive practices issues paper

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability published the Restrictive practices issues paper on 26 May 2020.

The paper outlined our preliminary understanding of some of the key issues regarding restrictive practices and people with disability.

The paper asked thirteen questions, although respondents were not limited to answering those questions.

Purpose of this document

This document provides a brief summary of what we have been told in responses to the Restrictive practices issues paper received by 2 November 2020. The responses expressed a range of views.

The purpose of this overview is to outline what we have heard through responses, however it is not an authoritative statement on the contents of those responses. This overview does not state the position of the Royal Commission on any issue.

Scope of this document

This document does **not** summarise what we have been told so far in submissions, community forums, private sessions or evidence at public hearings.

All information provided to the Royal Commission, including responses to issues papers, informs our work. That work will include further consideration on the use of restrictive practices on people with disability.

Who responded?

As at 2 November 2020, the Royal Commission had received 54 responses to the Restrictive practices issues paper.

We received responses from:

- Three representative organisations of people with disability
- Nine professional representative organisations
- Three advocacy organisations
- Four families of people with disability
- Fifteen disability service providers
- Six government bodies
- Four academics
- A person with disability, with the assistance of their social worker
- Nine other respondents, such as disability and health workers.

We did not receive any responses from people with disability who expressly identified as First Nations or culturally or linguistically diverse, or the organisations that represent them.

What did the responses say?

Responses to the Restrictive practices issues paper provided diverse insights into the use of restrictive practices on people with disability. This section outlines the overarching themes that emerged from those responses.

Understanding of restrictive practices

Some respondents gave feedback on the definition of restrictive practices. This input was about the need for greater clarity on what is meant by the term restrictive practices, along with concerns about the terminology itself.

Definitional issues

Some respondents expressed their views about how ‘restrictive practices’ were defined and explained in the issues paper.

Melbourne Social Equity Institute welcomed the comprehensive definition of restrictive practices used in the issues paper. It noted the difficulties associated with defining ‘chemical restraint’ and distinguishing it from medical treatment. It called on the Royal Commission to investigate the appropriateness of existing regulatory definitions including where a distinction is drawn between chemical restraint and medical treatment.

Lojic Institute suggested amending definitions of restrictive practices to take into account limitations and restraints which are less overt. For example, where the issues paper refers to limiting the ‘freedom of movement’ of people with disability, Lojic Institute suggested this should be broadened to limits to ‘freedom’. This would capture certain ‘lesser’ restrictive practices such as restrictions on a person’s social life, limiting access to foodstuffs, ‘lack of recreational activity’, and ‘neglecting the right to privacy’.

Lojic Institute also suggested expanding the definition of restrictive practices to include not just actions by a person, but also inactions. For example, it stated that a failure to consult a speech pathologist can limit a person’s right to communicate.

Occupational Therapy Australia noted that physical restraints should be distinguished from physical prompts. For example, if a person has a visual impairment, a physical prompt might involve touching them on the hand to complement verbal communication. They told us that this distinction is not always well understood, and needs to be more clearly described.

The New South Wales Trustee and Guardian told us that restrictive practices should be more clearly defined. For example, it said the National Disability Insurance Scheme Quality and Safeguards Commission does not necessarily regard cameras as a form of restrictive practice. However, they impose ‘seclusion’ on someone if ‘the person perceives that they could not leave or go to a specific area because of the cameras’. They suggested this area could be more clearly defined.

Other respondents suggested the need for national guidelines on restraint terminology and that all definitions of restrictive practices should include ‘worked examples’ to clarify the boundaries of ‘what counts’ as a restrictive practice.

Concerns about terminology

Some respondents expressed concerns about the appropriateness of the terms ‘restrictive practices’, ‘challenging behaviours’ and ‘behaviours of concern’.

Lancaster Consulting stated that definitions of restrictive practices are ‘too passive’, and should be more direct about the negative impact of restrictive practices on people with disability. It said those definitions would ‘benefit from a plain language qualitative statement about the impact’ they have on people.

People with Disability Western Australia (PWDWA) wrote that the terms ‘challenging behaviour’, and ‘behaviours of concern’ are problematic because they place the ‘focus on the behaviour as a ‘symptom of the disability’; pathologise ‘normal expressions of human emotions’; and treat the person and their behaviour as the problem. PWDWA emphasised that behaviours are often a way to communicate. PWDWA recommended that instead of using the terms ‘challenging behaviour’ and ‘behaviour of concern’, the Royal Commission should use the term ‘unmet needs’.

Autism Aspergers Advocacy Australia wrote that the terms ‘distressed or frustrated behaviour, or non-verbal communication are more accurate, informative and appropriate’.

Others held the view that the term ‘restrictive practices’ imposed negative connotations onto practices that were sometimes necessary to ensure the safety of people with disability. One respondent, the parent of a person with disability who lives in a group home, wrote that ‘Most’ of the examples of restrictive practices given in the issues paper ‘should be called abuse’ rather than restrictive practices. However, she suggested that some actions described by some as ‘restrictive practices’ are actually ‘safeguards for well-being’.

Nature and extent of restrictive practices

Responses to the issues paper provided insight into the nature and extent of restrictive practices used on people with disability. We heard about different types of restrictive practices, the prevalence of restrictive practices and the use of restrictive practices in different settings.

A number of respondents told us that restrictive practices are common and widespread. For example, Melbourne East Disability Advocacy told us that ‘[r]estrictive practices are used every day in the lives of people with disability’. One respondent, whose sister has a disability and lives in a group home, said that from her experience, restrictive practices might be used for the safety of the person with disability (or others), but at times are also used for ‘operational convenience’.

A number of disability service provider respondents told us that the most common form of restrictive practice is chemical restraint. An example of **chemical restraint** is using medication to sedate a person.

PWDWA wrote that it is ‘common for men with intellectual disabilities to be chemically castrated. Men with intellectual disabilities are often labelled as sex offenders when they express sexual desire or an interest in sex (e.g. watching porn and masturbation).’ They stated that women are given birth control without consent so that staff ‘do not have to assist with personal hygiene’, and to prevent ‘pregnancy in case of sexual assault.’

Multiple respondents told us about the use of **physical restraint.** Royal Australian College of General Practitioners told us physical restraints are more likely to be used for younger people with disability, and those with mental health conditions. An example of physical restraint could be holding a person down on the floor.

The Centre for Inclusive Education told us **‘seclusion’** is sometimes also referred to as an **‘environmental restraint’**, such as when a person is locked in a room. SA Health told us that of 320 restrictive practices used in the state’s health facilities in some eight months of 2020, about one third were seclusion (32 per cent).

Mechanical restraints were less commonly discussed in responses. Melbourne East Disability Advocacy suggested mechanical restraint occurs ‘behind closed doors’, making it difficult to know how often it occurs. Examples of mechanical restraint include ‘disconnecting the power of an electric wheelchair or taking a person’s communication device away from them.’

Lancaster Consulting told us they have ‘commonly witnessed’ **psychosocial restraint.** An example of psychosocial restraint could be constantly telling a person that doing an everyday activity is too dangerous, without reasonable justification.

Restrictive practices in different settings

Respondents told us restrictive practices can occur in different settings. Some respondents told us that restrictive practices are used widely in Australian **residential facilities** and accommodation settings such as Supported Independent Living and statutory care services such as Out of Home Care.

We were also told that restrictive practices are used within the **home.** The Benevolent Society wrote that in the ‘privacy of the home and family’, there ‘may be no formal decision-making process that protects people with disability.’ Thus, even where there are ‘the best of intentions, there is a tension between the perspective and interests of family members and people with disability.’ Concerns about ‘efficacy and informed consent’ may be considered ‘often irrelevant in the context of choices made to solve immediate challenges.’

Respondents told us that restrictive practices are used in **educational settings,** including primary and secondary schools. Australian Association of Special Education told us that anecdotal evidence suggests that the most likely forms of restrictive practices used in schools are extended periods of seclusion. The response from Children and Young People with Disability Australia (CYDA) discussed their 2019 National Education Survey, which had responses from 505 young people with disability, and families/carers of children with disability. CYDA wrote that the survey indicated that students experienced restraints including seclusion, being restrained with belts, and chemical restraint.

The Centre for Inclusive Education told us the lack of publicly reported data limits researchers’ ability to accurately analyse the extent to which restrictive practices are being used in education settings. It told us it is impossible to say with accuracy whether restrictive practices are more common in primary, secondary, mainstream or special/segregated education settings.

Speech Pathology Australia told us that once a person with disability has entered the **justice system,** ‘they are at risk of the unnecessary use of seclusion and/or restraints in response to displays of challenging behaviour’. It said this was ‘due to a lack of awareness, recognition and understanding by the justice system workforce, of the link between communication disability and such behaviour’.

We also heard restrictive practices are being used in **health care settings.** Royal Australian College of General Practitioners told us that restrictive practices that are ‘commonly seen or used within healthcare settings include’ chemical, physical and environmental restraints.

Prevalence of restrictive practices

The Lojic Institute, Royal Australian College of General Practitioners and other respondents stated there is limited data available to accurately determine the use and prevalence of restrictive practices on people with disability. The absence of data is a barrier to the development of evidence-based policy, procedures and practices. It also prevents evaluation of the impact of restrictive practices.

The Centre for Inclusive Education told us that ‘while data is not available through most education sectors, data collected by advocacy organisations provide some insight into the extent of restrictive practices in schools faced by students with disability’. For example, Children and Young People with Disability Australia’s 2019 National Education Survey indicated that one third of students with disability had experienced restraint or seclusion in the previous year.

Restrictive practices and intersectional considerations

Respondents suggested disproportionate numbers of First Nations people may be affected by restrictive practices. SA Health told us that Aboriginal or Torres Strait Islander people are at greater risk of restraint and seclusion as they are overrepresented in admissions to mental health services and psychiatric intensive care units.

Melbourne Social Equity Institute said that some literature suggests people from culturally and linguistically diverse backgrounds are subject to ‘higher rates of restrictive practices’, although there is ‘little such research’ in Australia.

PWDWA told us that specific cultural and spiritual needs of people from culturally and linguistically diverse backgrounds and First Nations populations have been the subject of restrictive practices in the past. These have included limiting engagement in traditional ceremonies, disallowing specific foods of cultural significance, or limiting engagement with other members of a particular cultural identity or spiritual belief.

Melbourne Social Equity Institute wrote that there is little existing research investigating women with disability’s experience of restraint and other restrictive or coercive practices in Australia.

Impact of restrictive practices

Respondents told us that restrictive practices can have a range of impacts on people with disability.

While several respondents told us that restrictive practices can prevent harm to people with disability or those around them, multiple negative effects were also identified. These include causing trauma and re-traumatisation of people, which in some cases can lead to suicidal ideation.

Some respondents told us there is a risk that restrictive practices will cause physical harm, poor health, reduced lifespan, and possibly death.

Respondents also told us that the use of restrictive practices may deny basic rights and respect for dignity to people with disability, and may be degrading. They noted that misuse of restrictive practices may subject a person with disability to cruel or inhumane treatment.

Using restrictive practices was identified as something that shaped norms. For example, Autism SA told us that the more that restrictive practices were used against people with disability, the more they were legitimised as ‘standard practice’. Other respondents told us that when the use of restrictive practices is normalised, it trivialises interfering with the rights and freedoms of people with disability, which ‘contributes to the dehumanisation of people with disability’.

Potential drivers of restrictive practices

Respondents told us about what they regard as factors that contribute to or drive the use of restrictive practices against people with disability. These factors include the unmet needs of people with disability; lack of resources and training in dealing with challenging behaviours; and cultural drivers, both in society and in workforces.

Failure to recognise and respond to unmet needs

Several respondents told us that behaviours deemed to be challenging and requiring restrictive practices are a form of communication that reflects unmet needs.

The Northern Territory Office of the Public Guardian (NTOPG) said the frequency of the use of restrictive practices is influenced by ‘the degree to which the needs of the person with disability are being met’. NTOPG said that factors driving the use of restrictive practices include ‘a health care system not equipped to respond to the individualised health, support, emotional and cultural needs of a person with disability’.

Lancaster Consulting Australia told us that behaviours may ‘escalate’ as a result of restrictive practices ‘not addressing the underlying need’ of a person with disability. This leads to the person becoming ‘increasingly insistent in their expression of this need’, leading to the use of more restrictive practices over time. This leads to restrictive practices becoming the ‘norm’.

Lack of resources and training in dealing with some behaviours

Multiple respondents told us that a lack of resources and lack of workforce training also contribute to the use of restrictive practices.

Melbourne East Disability Advocacy identified drivers of restrictive practices as including ‘[u]nderstaffing, low pay and lack of quality, frequent and relevant training’, and the ‘casualisation of the disability sectors workforce’. They wrote these factors lead to an ‘inability to provide quality support’, and a lack of ‘continuity of support for people with complex support needs’. According to the response, the ‘often underfunded, under-resourced environments can lead to the normalisation of a workplace culture that believes restrictive practice is the only viable and necessary approach’.

Other responses also considered staffing issues as directly related to the use of restrictive practices. For example, Melbourne Social Equity Institute considered ‘low staff-client ratios’ as an enabler of the use of restrictive practices, while People with Disability Western Australia suggested that a ‘lack of staff support and/or supervision’ can also be a contributing factor. Other responses, such as the NTOPG considered ‘insufficient resources and funding’ on a broader level, including those necessary to ‘provide person centred and individualised support’ as key drivers for the use of restrictive practices.

Lack of relevant supports may also be considered relevant to the use of restrictive practices in the community. The Benevolent Society wrote that they are used by families ‘to protect themselves and their loved ones in the absence of other support or strategies’.

Cultural drivers in workforce and society

A number of respondents submitted that cultural factors were key drivers for the use of restrictive practices. These factors include certain attitudes towards people with disability and workplace cultures.

Lancaster Consulting Australia attributed the use of restrictive practices to a ‘lack of fundamental respect for the human rights’ of people with disability. It told us that if a service has a ‘culture of bullying and intimidation’, staff will ‘often use many’ restrictive practices. Restrictive practices may also be used where staff become ‘task focused’ rather than ‘person centred’.

NTOPG likewise identified a factor in the use of restrictive practices was a ‘lack of awareness and understanding of the rights of people with disability and/or negative or indifferent attitudes towards people with disability’.

Autism South Australia identified a driver as the cultural sense that ‘this is how it has always been managed’, and ‘[m]odelling of [restrictive practices] by senior staff as standard practice’. Advocacy Tasmania said that frequent use of restrictive practices creates a perception that it is a ‘normal or acceptable way of handling a situation’, and ‘creates a culture’ that ‘undermines the rights people with disabilities’.

People with Disability Western Australia wrote there is ‘a “risk averse” culture in disability settings’, where the focus is on ‘preventing the worst possible outcome, no matter how small the possibility. The result of this is often a restrictive practice that is not proportional to the probability of the risk occurring.’

Some respondents identified ‘convenience’ for staff as a contributing factor to the use of restrictive practices and an ‘easier short term response to behaviours of concern’. For example, Lojic Institute wrote that restrictive practices may be used for ‘convenience’, or ‘organisational simplicity’; and are commonly used in response to behaviours which are ‘not necessarily’ harmful but are ‘simply … unpleasant or inconvenient’. It told us that alternatives to restrictive practices may ‘often require a high level of expertise, more effort and time, and ongoing staff training’.

Different perspectives on permitting restrictive practices

We heard different perspectives on whether and, if so, when restrictive practices should be permitted.

Whether restrictive practices should be permitted

Some respondents told us restrictive practices should be permitted in some circumstances. Most commonly, respondents said restrictive practices should be permitted for the purpose of protecting the safety of a person with disability, or people around them.

People with Disability Western Australia wrote that restrictive practices may be permitted, provided that they prevent a risk of harm, and are used as a last resort. CYDA likewise thought restrictive practices could be permitted where they are an 'absolute last resort', that the 'least restrictive practice' should be used where possible, and for the 'shortest time possible'. It stated that governments should adopt an approach to 'reducing and eliminating restrictive practices across all settings'.

New South Wales Trustee and Guardian recognised that restrictive practices pose a 'significant infringement' on a person's human rights, and should be used with conditions discussed in the next section. They also wrote that restrictive practices 'can offer opportunities for quality community participation or ensure maintenance of the person's health'. An example given is a person with disability who removes her clothes 'in public settings'. Her 'behaviour support plan' includes wearing a bodysuit 'to limit her ability to remove her clothes'. They argue that this 'has enabled her to continue the activities she enjoys and maintain her dignity.'

Other respondents told us that restrictive practices should be eliminated entirely. One response from a social worker characterised restrictive practices as 'actively harmful', 'inappropriate, often counterproductive, and dangerous'. The respondent argued for changes which will 'contribute to an eventual significant reduction' in the use of restrictive practices, and 'the complete elimination |of restrictive practices used "under the guise of 'behaviour modification'", as has been called for by The United Nations' Committee on the Rights of Persons with Disabilities'.

Similarly, the Centre for Inclusive Education told us '[r]estraint and seclusion breach fundamental human rights including autonomy, bodily integrity, and liberty', and may be 'degrading'. It wrote that international human rights law is 'clear' that state parties are obligated to reduce and eliminate the use of restrictive practices in schools.

Benevolent Society stated that it knows 'from experience that restrictive practices can be eliminated and reduced through multi-disciplinary and holistic services for people with a disability'.

Where and when restrictive practices should be permitted

For those who did not support legally prohibiting all uses of restrictive practices, there were different perspectives on the circumstances in which restrictive practices should be permitted, and the safeguards which should be placed on their use.

Multiple respondents were of the opinion that restrictive practices should be used as a last resort to prevent a person with disability from harming themselves or others. For example, Lifestart Cooperative Limited stated that restrictive practices may be needed where there is a risk of harm that cannot be 'effectively managed by more positive approaches'.

Some responses focused on whether the use of a restrictive practice was justified by the harm it was seeking to respond to or prevent. PWDWA stated that any use of restrictive practice 'should be proportional to both the type of harm, and the risk of it occurring'. That response noted that '[t]here is a tendency to approach risk with an all-or-none attitude focusing on preventing the worst possible outcome, no matter how small the possibility. The result of this is often a restrictive practice that is not proportional to the probability of the risk occurring'. Examples of harm that PWDWA gave as potentially justifying the use of a restrictive practice included 'imminent' harm caused by diet, a person walking unsafely on the road, or an imminent assault.

Both NSW Trustee and Guardian and Association of Independent Schools of Western Australia (AISWA) supported the same principles of last resort, preventing harm and proportionality. AISWA also supported clear policy outlines for their use, and that their use should be 'reported and/or documented'.

Some respondents wrote that restrictive practices could only be appropriately used as part of other broader strategies, such as within positive behaviour support plans. The Northern Territory Office of the Public Guardian was critical of the use of 'restrictive practices in the absence of positive behaviour support and a legislated authorisation and monitoring framework for the use of those practices' across 'all service sectors'. Where restrictive practices occur, 'their use must be specifically justified and authorised'. A number of respondents argued that positive behaviour support was an appropriate alternative that could help minimise and prevent the use of restrictive practices.

Other responses suggested that specific conditions should be placed on the use of restrictive practices. For example, Autism Aspergers Advocacy Australia wrote that any restrictive practice 'must only be allowed when it addresses problems in an appropriate, informed and effective manner. Otherwise, it is abuse, punishment and/or cruelty'.

Relationships Australia told us restrictive practices should only be permitted 'within a human rights framework that maximises autonomy'. That framework of requirements includes a supported decision making model, national consistency, and clear and accessible reporting mechanisms.

The need for accountability and transparency in the use of restrictive practices was common throughout responses which did not call for their outright prohibition. For example, the Office of the Public Advocate Victoria wrote that use of restraints 'must be justified in each instance'.

It submitted that restraints should only be used for therapeutic purposes, in the 'least restrictive way possible in the circumstances', authorised by an appropriate legal body, and 'with appropriate independent advocacy support' provided to the person in question.

Proposals for change

Respondents to the issues paper proposed a range of changes for the Royal Commission to consider, including supporting promising practices that prevent, reduce or aim to eliminate restrictive practices.

The proposals for change were primarily in the areas of reforming attitudes and culture; training and education; laws and policies; funding; and data collection and reporting.

Attitudes and culture

Several respondents told us about how to address attitudes and culture, in order to prevent and minimise the use of restrictive practices. Such proposals included:

- Improving staff and organisational culture, through committed leadership and other measures to support respectful workplaces.
- Promoting a staff culture that is committed to respecting and understanding disability and diversity and explicitly promoting all environments as welcoming and accommodating. We were told that such a culture can prevent the use of restrictive practices by promoting a person's autonomy, understanding, respect for differences in behaviour, and encouraging people's communication.
- Educating the community about the rights of people with disability and the need to reduce and eliminate the use of restrictive practices.
- Changing service provision culture from a safeguarding approach to a human rights approach.
- Transforming regulatory culture so there is a considered approach to using sanctions.

Training and education

Some respondents told us about the role of training and education in preventing and minimising the use of restrictive practices. Proposals to improve training and education included:

- Educating people with disability about their rights and what constitutes a restrictive practice.
- Disability service providers engaging with families and carers of people with disability to prevent the use of restrictive practices.
- Improving workforce training in positive behaviour support and applied behaviour analysis.
- Improving training for mental health practitioners, carers and family members on trauma-

informed, recovery-oriented and consumer-focused care, as well as de-escalation and debriefing techniques.

- Ensuring staff understand and uphold the rights of people with disability, and how these apply in relation to restrictive practices.
- Encouraging structured workforce planning for support workers so that staffing profiles correspond to needs of people with disability and potential risk of harm.

Laws and policies

National regulation and frameworks

Several respondents told us that the laws, regulations and guidelines for the use of restrictive practices were inconsistent and unclear. Proposals to address these matters included:

- Co-designing the process that regulates the use of restrictive practices to ensure the development of outcomes valued by people with disability and that it supports the 'fullest exercise of their human rights'.
- Aligning regulation of restrictive practices with Australia's obligations under the *Convention on the Rights of Persons with Disabilities (CRPD).* This includes ensuring that legislation and policies prioritise reducing and eliminating the use of restrictive practices, and provide comprehensive and practical guidance on alternatives.
- Establishing and implementing a 'sufficiently resourced' National Preventive Mechanism (NPM), in close consultation with people with disability and their representative organisations. The remit of a NPM must include disability, mental health and aged care settings.
- Ensuring that Australian, state and territory governments commit to establishing a national authorisation and monitoring framework for the use of restrictive practices on people with disability. We were told that this framework should extend across all service sectors, and be aimed at reducing and eliminating the use of restrictive practices on people with disability. Furthermore, legislative reform should ensure 'accountability, transparency and sanctions' and laws and regulations should be gender-sensitive.
- Ensuring a national framework and NPM:
    - are based on human rights principles, including the *CRPD* and the *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)*
    - define terminology clearly and accessibly, so that it can also be used by families and support people. Definitions of restrictive practices should include 'worked examples' to clarify the boundaries of 'what counts' as a restrictive practice.
- Establishing a national independent monitor of restrictive practices. An independent monitor could evaluate the risk of harm, circumstances surrounding the event, and the use of restrictive practices and behaviour support generally. It could also examine inclusive practices that would

reduce the use of restrictive practices. One respondent proposed this should apply in schools. Another proposed this should apply in all settings where restrictive practices are used.

- Introducing national mandatory reporting around all use of restrictive practices. We heard that there should be legislative protections for complainants, their families and support workers. There should also be ‘clear complaints pathways’ for people with disability, their supporters and whistleblowers.
- Establishing a ‘National Framework for Positive Behaviour Support’. This could create national standards, including definitions; a single reference point for assessments, practice and outcomes; minimum accreditation and qualification standards; and mandatory guidelines for service systems with clients with behaviour support needs.
- Preparing a broad policy ‘charter’ or ‘framework’ that collates research evidence and findings on alternatives to restrictive practices that have been introduced and tested, or warrant further investigation.
- Ensuring laws regulating restrictive practices are in primary, not delegated, legislation. We heard that such laws should have ‘sunset’ clauses, which results in them expiring automatically at a certain date. This would ensure that they can be updated in accordance with new evidence. Furthermore, laws should be premised on a supported decision making model.

Regulation of requirements of professionals

Several respondents told us that additional or strengthened regulatory approaches are required to ensure that staff working with people with disability receive adequate training around the use of restrictive practices. Proposals included:

- Developing clear and consistent standards for the training that staff require in order to implement restrictive practices.
- Mandating training for support workers on relevant restrictive practices legislation and its application.
- Requiring formal recognition and professional registration for behaviour support clinicians and behaviour analysts. One respondent supported establishing a national regulatory body to oversee the professional practice of behaviour analysts and support clinicians. Another respondent said the accreditation process should be outcomes focused and stratified according to risk profile.

National Disability Insurance Scheme (NDIS)

A number of respondents told us about proposals to reform NDIS laws, policies, guidelines and practices. The proposals included:

- Providing funding to all participants in the NDIS to develop their self-advocacy skills.
- Expanding positive behaviour support provided under the NDIS so that consistent behaviour support strategies can follow participants across all sectors, including health, justice and education.

- Adapting the NDIS restrictive practice guidelines to acknowledge the use of sensory approaches and equipment as an alternative to restraints.
- Enabling the use of NDIS funds to purchase low-cost sensory equipment and everyday items prescribed by an occupational therapist for therapeutic purposes.
- Building capacity and awareness among NDIS planners about restrictive practices, and the type and amount of funding required for positive behaviour support services. This includes, but is not limited to, ‘Improved Relationships’ funding.
- Requiring providers who register for behaviour support services to demonstrate an understanding of all relevant legislation, the Positive Behaviour Support Model, the Active Support Model, person-centred care and the social model of disability.
- Amending existing policies so that behaviour support plans can only be completed by a practitioner who is not from the same organisation as the Supported Independent Living or Supported Disability Accommodation implementation service provider.

Funding

We heard from some respondents about proposals to prevent and minimise the use of restrictive practices through an allocation of funding or changes to funding models. The proposals included:

- Funding decision-making supports for people with disability.
- Increasing resourcing of self-advocacy groups and peer networks to help people understand their rights, develop the confidence to speak up, and be empowered to support and advocate for themselves and others.
- Encouraging, developing, and funding programs that assist people with disability to develop wide informal support networks.
- Redesigning funding models around behaviour support so they support a coordinated, multi-disciplinary approach; training and coaching; and ongoing monitoring of behaviour support plans.
- Providing professionals with the time and funding required to conduct functional behaviour assessments and develop behaviour support plans; as well as working collaboratively with parents, educators, and/or support workers to support them in implementing behaviour support strategies.
- Increasing the hourly rate paid by the NDIS for behaviour management plans and implementation to reflect the additional requirements of this work.
- Funding the NDIS Quality and Safeguards Commission to employ experts to review behaviour support plans and follow up with providers to take corrective action when critical components are missing or not satisfactory.
- Under the NDIS, restricting who guardians can choose as providers for the participant. Guardians should not be able to choose unregistered providers if the participant: is in |foster care; has funding for improved relationships in their capacity building budget; or presents with behaviours of concern that are commonly managed with restrictive practices.

- Amending existing policies so that the core support budget cannot be self- or plan-managed for participants who are: in foster care; have funding for improved relationships within their capacity building budget; or present with behaviours of concern that are commonly managed with restrictive practices.
- Increasing NDIS funding for positive behaviour support for young people and children. This should include funding for capacity building of family and other carers, and skill building for young people. It should also include funding to train teachers and educators working in early childhood, school environments, and other mainstream settings.

Other proposals

Other ideas we heard to prevent, minimise and eliminate the use of restrictive practices included:

- Establishing peer review committees, consisting of people with disability and professionals from multiple disciplines. These committees would have educational and clinical expertise in assessing and treating behaviours of concern, positive behaviour support, data collection and analysis.
- Ensuring people with disability have access to appropriate supports for communication and decision-making, in particular when consenting to practices that may be restrictive. This also includes capacity-building supports for consumers to develop advance statements under the Victorian Mental Health Act, and supports for practitioners to implement them.
- Creating a clear and transparent recording and notification process for all uses of restrictive practices. In doing so, where appropriate, the family or guardian of the person with disability should be notified of the use of a restrictive practice.
- Improving data recording, collection and analysis around restrictive practices and behaviour management, including behaviour supports, relevant needs and outcomes. One respondent suggested that the NDIS Quality and Safeguards Commission should publish data in relation to the use of restrictive practices along with a thematic analysis of their use.
- Identifying gaps in the research evidence about alternatives to restrictive practices and conducting more research into practical, implementable alternatives that can reduce the use of restrictive practices. This should include gender-sensitive analyses of alternatives.

How will we use the information we received?

All information provided to us, including all responses to issues papers, is carefully considered by the Royal Commission. It informs our ongoing work, including public hearings, policy processes and our research agenda. It will also inform our Final Report and help us to develop our recommendations.

Support

Blue Knot Foundation offers specialist counselling support and a referral service for anyone affected by the Disability Royal Commission.

For support please call their national hotline on **1800 421 468** (9am to 6pm AEST Monday to Friday, 9am to 5pm AEST Saturday, Sunday and public holidays).

In addition to the Blue Knot Foundation, the Australian Government provides support to assist people to engage with the Royal Commission. This support includes:

- free legal advisory services provided by National Legal Aid and the National Aboriginal and Torres Strait Islander Legal Services through the Your Story Disability Legal Service
- advocacy support services provided under the National Disability Advocacy Program.

Further information about these supports, including how to access them, is available on the counselling and support section of our website.

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