We would like to hear more about how the use of restrictive practices can be avoided. This includes hearing about alternative measures and strategies to restrictive practices to ensure people are safe and protected from harm.

Questions

Please answer as many of these questions as you wish. You do not need to answer them all and your response does not have to address any of the questions.

If you wish to share an individual experience of the use of restrictive practices, please consider making a submission. You can contact us in writing, by telephone or by sending a video. More information is on our website.

Question 1: What are restrictive practices? Does the explanation in this paper need to change?

We believe the Disability Royal Commission's definition of restrictive practice as stated in this issue paper is a sound definition.

"Approach or intervention that has the effect of limiting the rights or freedom of movement of a person.[44]

Restrictive practices include:

- **seclusion**, where a person is confined to a physical space and prevented from leaving. An example is locking a person in a room for a set period of time.
- the use of **restraints**, which may be:
    - **physical**, for example, holding a person down on the ground so they cannot move in a hospital
    - **chemical**, for example, using medication to sedate a person
    - **mechanical**, for example, tying a person to a chair in a classroom, disconnecting the power of an electric wheelchair or taking a person's communication device away from them
    - **environmental**, for example, locking a garden area or fridge in a group home to stop people accessing it
    - **psychosocial**, for example, constantly telling a person that doing an everyday activity is too dangerous, without reasonable justification.[45]"

In addition, the following should be considered as forms of restraint:

- 'Power Control' and 'Consequence Control as highlights in NDS's 'Zero Tolerance' film series 'Recognising Restrictive Practices'.

- Legal restraint (restricting someone's legal rights).

Question 2: What types of restrictive practices are applied to people with disability? Are certain types of restrictive practices more common than others?

All the types of restrictive practice listed above are applied to people with disabilities. In our experience as advocates it is observed that restrictive practice in its many forms are widespread in their use against people with intellectual disabilities.

Chemical restraint

Working in the disability sector as advocates we know that restrictive practices are widely used. One of the most common restrictive practices that we come across is the use of Chemical restraint.

Chemical restraint in institutional and service settings:

The belief that peoples 'behaviours' need to be managed by chemical restraint is still widely accepted within many institutional and service settings. Many people residing in institutional and service settings are subject to this form of restraint. Understaffing, low pay and lack of quality, frequent and relevant training can result in the inability to provide quality support. The casualisation of the disability sectors workforce also prevents continuity of support for people with complex support needs as well as preventing meaningful relationships, trust and understanding to develop.

These 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. As advocates we often observe a lack of/or poor knowledge of what restrictive practices are, and the important of reducing/eliminating their use in many institutional and service settings. The widespread lack of awareness of this issue needs to be address through a variety of awareness raising mechanisms.

Recommendations to address this issue:

- We have observed long waiting times in relation to accessing behavioural support practitioners – and we believe this wait would contribute to the use of chemical restraint. We recommend that more positive behaviour practitioners become available to match the demand.
- Increased staffing and quality, relevant and meaningful training

Chemical restraint in family and informal settings:

Chemical restraint also occurs within family and informal settings. As there is less oversight in these environments', the supporter is less likely to be kept accountable in relation to how they use this form of restraint, putting the individual at higher risk.

Environmental restraint:

Environmental restraint is also something we see frequently within a variety of settings, including institutional, service, and informal (family). It is not uncommon for fridges and pantries to be locked, as well as house doors and bedroom doors, resulting in people being unable to enter their own private spaces. Within institutional/service settings we have seen circumstances where certain seating is allocated to certain individuals within the home and doors locked to enter or leave the premises. Often these restraints are in place in efforts to response to 1 individual residing in the home, however the rest of the home is fully impacted by the restrictions. Not enough is being done to ensure that the least restrictive practice is used within these environments. It is often not until someone independent like an advocacy agency challenges this practice that a forced change occurs. Often there is lack of awareness in the homes around these practices being considered a restrictive practice, and a lack of knowledge around the fact that restrictive practices should only be used in a way that follows current policies and legislation. This lack of awareness results in a widespread lack of reporting on the unauthorised use of this practice.

Environmental constraint also involves restraining an individual in accessing their belongings. This way of using restrictive practice is also common within service, institutional and family settings.

Psychosocial restraint:

Is something that many people with disability are subjected to from a young age. They are constantly being told of the things they can't do instead of encouraging them to explore and increase their life experiences. The concept of protecting people from different experiences, events and or everyday lifestyle choices is still forefront of people who work in the disability sector and many family members. Family members, disability sector staff and the broader community often continue to struggle with the idea that people with intellectual disabilities have the right to have choice and control over decisions that affect their lives. Family members, disability sector staff and the broader community also continue to be limited in their understanding of the importance of supported decision making, as well as the importance of reducing/eliminating substitute decision making practices. Often it takes the involvement of an individual person such as an advocate for there to be recognition the need to platform the voice, will and preferences of the individual with intellectual disability.

Psychosocial restraint is widespread in the lives of people with intellectual disabilities. Those close to them and those in the broader community often assume that they do not

have a right or the capacity to have choice and control over decisions that affect their lives, learn new things, work, study, have sex or be in a relationship etc.

People with intellectual disabilities are often denied the opportunity to engage in romantic or sexual relationships of any kind.

People with intellectual disabilities frequently experience restraint regarding access to their finances.

People supporting people with intellectual disabilities also frequently use consequence control and power control.

Legal restraint:

Legal restraint is another form of restraint that people with disability experience. E.g. Guardianship and Administration orders placed on the individual or removal of child through child protection.

Physical and mechanical restraint:

Is something we do not see a lot of; however, we would believe that this type of restraint would still be occurring in the disability sector. This restraint would be done behind closed doors making it very difficult to know how often this occurs.

Attitudes and Discrimination: are a type of restraint in a range of environments that impact on an individual's capacity to feel valued, to flourish and to contribute.

Question 3: How often are people with disability subjected to restrictive practices?

Restrictive practices are used every day in the lives of people with disability.

In recent years, the use of restrictive practice is more widely discussed in the disability sector and the principle applied is to use least restrictive practice, however the use of restrictive practices (often unauthorised) is still widespread. This culture is embedded within the disability sector and family homes. At times, this may be thought of by the individual using this practice as the only strategy they known regarding how to respond to a certain circumstance. Awareness raising and quality training should be made available to build the skills of those supporting.

Often, despite less restrictive strategies being put in place as an alternative, staff or family members continue the use of restrictive practices, often, due to lack of time and resources to use least restrictive practices. Least restrictive methods of support can take time and patience however services may not be sufficiently resourced in a way that enables them to provide this quality support.

Case example of why MEDA has concerns of widespread use of restrictive practice:

Case:

[redacted] Meda were contacted by an operations manager alerting us of a staff assault to a resident in a group home. At that time, they also disclosed using restrictive practice in the home by strapping all the cupboard doors and using a fridge alarm in the home. Since the incident these restrictions have been banned within this group home.

Concern: Advocacy was not engaged due to the use of restrictive practice. The service only banned the use of this practice as a result of advocacy engagement. We have concerns regarding how many other services may not be reporting the use of unauthorised restrictive practises.

Family use of restrictive practice:

As advocates we are also aware of restrictive practice occurring within family homes and amongst family members. There can be a history of people with disability being denied their rights and all forms of restriction being applied. The challenge is there is often less oversight in family environments or if raised that family members act with restriction then this can be met with hostility and defensiveness.

Question 4: Where or in what circumstances are restrictive practices used?

Service and Institutional settings:

We have witnessed the use of a wide variety of restrictive practices within institutional and service settings.

- Chemical restraint in efforts to change behaviours.
- Locking of fridges, and doors within the home to keep others from entering spaces.
- Locking of front and back doors.
- Locking of bedrooms and cupboards where clothing is kept so unable to access belongings easily.
- Many residents are restricted in the choice and control that is made available to them within their lives and have staff who make choices for them without involving them in the decision.
- Harnesses and extra seatbelts in vehicles.
- TV and remotes behind secure cabinets.
- Consequence control: Threats of removing people's personal items from them consequently for doing/not doing something.
- Psychosocial restraint: People being told that they cannot do things for themselves, cannot attain a goal of theirs, cannot have wants and needs met, or learn new things. Staff refusal in allowing people with intellectual disabilities to have sexual or romantic relationships or experiences. Controlling individuals access to their belongings or finances.

Note: Often, in circumstances where restrictive practices are used in response to one resident within supported accommodation, all residents are impacted by the use of this restriction (eg. When fridge or pantry is locked).

SRS boarding houses:

There would be multiple forms of restrictive practises used within these facilities. Many people all with varying disability in confined spaces, all requiring individual care where many people are highly vulnerable. Minimal rostered staff along with staff with basic qualifications leave no time to support behaviours of concern, with the perceived easiest option being to use restrictive practices.

- Kitchens and dining areas locked when not in use.
- Bedroom doors always locked
- Many residents on psychiatric medication which is a chemical restraint.
- Curfew times of facility.

Family homes

- Attempts to control behaviour through chemical restraint.
- Blocking off areas within the home restricting an individual's access to other areas in the home.
- Families locking people in bedrooms.
- Restricting outings.
- Families not accepting that people with disability can make choices for themselves therefore restricting their input into decision making. Not listening and acting on their wishes.
- Restraining individuals' access to their own finances, resulting in extreme limits on their everyday choice and control. Not involving individual or taking into consideration their will and preferences when making these decisions for them.
- Psychosocial restraint occurs within this environment in a wide variety of ways and its use is normalised in the lives of people with intellectual disabilities. Some examples of the use of this restraint is restricting or deny the individuals ability to engage in romantic or sexual experiences or relationships, consequence control and controlling access to the individuals property (device, toy etc).

Legal and criminal justice system:

People with disabilities are disproportionately represented in the criminal justice system and within incarcerated populations. Incarceration is a systemically used form of restraint.

People with disabilities also frequently experience legal restraint in other forms mentioned previously such as via Guardianship or Administration orders.

Question 5: Why are restrictive practices used?

Restrictive practice means any **practice** or intervention that has the effect of restricting the rights or freedom of movement of a person with disability.

Restrictive practice controls the behaviours and lives of people. The idea of restrictive practice is to decrease behaviours that may involve harm to the individual or others, giving the individual a better quality of life, but often we see the opposite occurring. Overuse of medications i.e. PRN medications when behaviours increase is common practice within the disability sector. We often see people on a cocktail of medications that may not always be in the best interests of the individual. A staff culture within service/institutional settings which thinks 'when behaviours increase PRN medication has been administered' has been commonplace. However, there is now a shift to work with individuals and behaviour support specialist to develop the least restrictive strategies possible, but there is still a long way to go in this area.

Limiting areas within the home is common practice to control and limit certain behaviours in individuals. Restricting space to individuals within their home can be view as an easy solution to staff who are unavailable and under-resourced to support an individual in a less restrictive way.

At times restrictive practices might be used as a mechanism for controlling another person or for making life easier or less problematic for care providers, a fine line between restrictive practice and abuse.

Question 6: What are the effects of restrictive practices?

- Trauma
- Oppression
- Removal of human rights
- Devaluing of people with disability
- People feeling controlled, violated and losing hope
- Significant mental health impacts
- Reinforcing of negative attitudes, stigma and stereotypes
- The line between restrictive practice and abuse is grey – and thus the effects of restrictive practice can be the experience of violence and abuse.
- Can often result in increased distress, resulting in the individual communicating this through 'challenging' behaviour.

Question 7: Is the use of restrictive practices different for particular groups of people with disability? If so, how?

A. How is the use of restrictive practices on people with disability of different age, sex, gender identity, sexual orientation and race different? Are restrictive practices used on them at higher rates?

The restriction of people with disability's sexual rights are commonplace, particularly for people who have intellectual disabilities and/or are LGBTIQA+.

B. How is the use of restrictive practices on First Nations people with disability different? Are restrictive practices used on First Nations people with disability at higher rates?

We would recommend robust consultation with the First Nations people

C. How is the use of restrictive practices different for culturally and linguistically diverse people with disability different? Are restrictive practices used on culturally and linguistically diverse people with disability at higher rates?

People with intellectual/cognitive disability:

People with intellectual / cognitive disability are at greater risk of experiencing all types of restrictive practice measures alongside people with complex, limited communication.

People with intellectual disabilities are often denied and refused the opportunity to engage in any sexual or romantic relationships.

Question 8: Does the use of restrictive practices lead to further violence and abuse, neglect and exploitation of people with disability? If so, how?

Restrictive practice with no oversight can lead to forms of abuse, violence, neglect and exploitation. It may be viewed as a way of containing an individual rather than considering someone's communication needs to address frustration or presenting behaviours.

The use of unauthorised restrictive practices with no oversight can also reinforce negative attitudes and beliefs about people with disability needing to be contained and controlled.

Question 9: Are current approaches to restrictive practices effective? This may include laws, policies, principles, standards and practices.

A. Are there any gaps in the current approaches?

Legal restraint: When applying for VCAT for a Guardianship or Administration order, often a medical report is required as 'evidence' that the individual does not have capacity. Often, there will be a GP appointment which allows for the development of this report. We have seen and been informed of questionable practices by GPs in these settings. Examples of these questionable practices are: GP's not speaking directly to the individual the report is concerning but only to the

family member seeking legal authority. GP's writing these reports without meeting with or seeking to communicate with the individual themselves – having only spoken to the family member seeking legal authority.

Lack of awareness around all types of restrictive practice:

We have observed a widespread lack of awareness and knowledge around all types of restrictive practice within disability sector staff, services and families. There is often a lack of understanding of the less known restrictive practices such as 'environmental restraint' and a lack of knowledge around the authorisation required to allow the use of this.

Lack of oversight for families:

Currently there is a lack of oversight is practices conducted by family members.

B. If so, what are the impacts of these gaps?

Legal restraint:

The impact of the gap listed above concerning legal restraint is:

The lack of involvement or voice of the individual concerned, leaving them at risk of being unnecessarily oppressed further by the law.

Lack of awareness around all types of restrictive practice:

This results in a mass underreporting of restrictive practice use. This also results in the unnecessary and unauthorised removal of many people with disability's rights.

Lack of oversight for families:

This results in the lack of ability to keep families accountable if using unauthorised restrictive practice.

Question 10: In what circumstances may restrictive practices be needed?

A. What rules and safeguards should be apply?

B. Should the same rules apply to all people?

Question 11: How can the use of restrictive practices be prevented, avoided or minimised?

A. What needs to change in laws and polices?

B. What needs to change in the community and within organisations?

Free, paid for training to all staff and supporters regarding restrictive practices and the importance of the movement towards minimising/eliminating their use.

A cultural shift within the community and organisations which deeply values the importance of moving away from the use of restrictive practices whenever possible.

C. What are the barriers to this change?

Addressing widespread needs of people with disability:

Often 'behaviours of concern' can be a means of communicating a need. We know that many people with disability live in inappropriate housing, lack access to appropriate health care, experience high rates of discrimination, violence, abuse, neglect and exploitation, and experience ample barriers to access and inclusion in their lives. Addressing widespread, systemic issues experienced by many with disability will contribute to the prevention of 'behaviours of concern' while simultaneously meeting Australia's obligations under the UNCRPD.

Ill-informed support network:

Often families and staff are not informed that the practices they are using are forms of unauthorised restrictive practices. We see this frequently in relation to environmental restraint.

Often negative attitudes about disability leads family member, staff and the broader community to think it is okay to practice the use of financial restraint, consequence control, power control and psychosocial restraint. It is important that these a recognised as forms of abuse (excluding financial restraint if legally authorised), however often their practice is normalised and accepted.

Wait times to access professional support:

An additional barrier to reducing the use of restrictive practices is (when relevant) the often long wait times in relation to accessing professional support such as Behaviour Support Practitioners or Speech Therapy.

Question 12: What alternatives to restrictive practices could be used to prevent or address behaviours of concern?.

Communication:

Comprehensive communication plans and options incorporated within every person's plan with complex or limited communication

Consequence control, power control and psychosocial restraint:

To eradicate consequence control, power control and psychosocial restraint, knowledge of what these are and the fact that they are common, widespread forms of abuse towards

people with intellectual disabilities needs to be widely acknowledged and understood. The current lack of awareness around this needs to be address.

Disability sector staffing:

- More staffing in group homes and other services which would allow for quality, meaningful support for individuals who may have complex support and/or communication needs.
- Increase staff training to ensure quality, person centred, rights aware support is provided.
- Address the issue of a casualised workforce in disability services – often leading to a lack in wholistic and informed support practices.
- Free widespread training and awareness raising of forms of restrictive practice and abuse within the disability sector and for families and supporters of people with disability.

Availability of professional supports:

- More funds available in NDIS plans to fund behavioural specialist professionals
- More allied health professionals such as Psychiatry and psychologists in the Public Health System to have easier access to professional services. Having to wait for these services for such long periods of time can be damaging to the individual seeking support.

Question 13: Have we missed anything? What else should we know about restrictive practices?

Responding to this issues paper

Responses to this issues paper can be provided by:

- email to DRCEnquiries@royalcommission.gov.au
- letter to GPO Box 1422, BRISBANE QLD 4001
- phone on 1800 517 199 or +61 7 3734 1900 (between 9:00am to 5:00pm AEST Monday to Friday). We can make a time with you to take your response over the phone.

Responses can be in writing, an audio recording or a video recording. Responses can be in any language. The Royal Commission will translate the response to English.

We encourage responses by [**28 August 2020**], however responses will also be accepted after this date.