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Executive summary

Purpose of the research

This report provides guidance to the Disability Royal Commission in relation to the Commission's objective to reduce and eliminate restrictive practices. Restrictive practices are at odds with the human rights of people with disability and represent a significant form of violence and coercion. The following definition of restrictive practices has been devised by the authors of the report based on the findings presented in the report, and is for use in the report and elsewhere:

Restrictive practices are legally authorised and/or socially and professionally sanctioned violence that targets people with disability on a discriminatory basis and are at odds with the human rights of people with disability. Restrictive practices include, but are not limited to, chemical, mechanical, physical and environmental restraint and seclusion, guardianship, forced sterilisation, menstrual suppression and anti-libidinal medication, financial management, involuntary mental health treatment, and other non-consensual or coercive interventions said to be undertaken for protective, behavioural or medical reasons.

Scope: Objectives and research questions

The Disability Royal Commission set five core objectives for the research project:

1. To identify and analyse systemic drivers of the use of restrictive practices across settings across Australia.

2. To identify and analyse strategies to reduce and/or eliminate the use of restrictive practices and exclusion.

3. To examine whether the existing findings of the Royal Commission in relation to positive behaviour support generalise in relation to other types of restrictive practices and disabilities. Here we note that Public Hearing 6 did not provide sufficient evidence to determine why positive behaviour support may be viewed by some as a best practice response to perceived 'behaviours of concern', nor if positive behaviour support is effective in reducing the full range of restrictive practices used against all people with disability.

4. To undertake this research in alignment with the Terms of Reference of the Royal Commission.

5. To inform the Royal Commission's policy development, identification of possible solutions, and recommendations for its final report.

The Disability Royal Commission set the following research questions for the research project:

RQ1: What are the systemic drivers of the use of restrictive practices against people with disability? How do these differ across settings across Australia?

RQ2: What measures and strategies are most effective in addressing these drivers and reducing or eliminating the use of restrictive practices against people with disability?

Does this differ by setting, or by the type of restrictive practice? What measures have been proven ineffective in addressing restrictive practices?

RQ3: Is positive behaviour support effective in reducing and eliminating the use of restrictive practices? Is it more effective in relation to certain types of disabilities, certain restrictive practices, or certain settings?

RQ4: Are there local and international models of policies and practices that have resulted in effective reduction in the use of restrictive practices?

Methodology

The research project adopted a disability human rights methodology. The project included elements that were both participatory and emancipatory: involving representatives from Disabled Peoples Organisations in all phases of the project and seeking explicitly to arrive at conclusions that realise the rights of people with disability. Data collection and analysis was undertaken in three, connected parts:

1. **Centring the experiences and rights of people with disability.** The project centred the experiences and rights of people with disability. A review of relevant scholarly literature, reports and submissions containing secondary empirical data was conducted to capture lived experiences of people with disability subject to restrictive practices. As described below, due to time constraints, it was not possible to conduct a new empirical study of these experiences.

2. **Expert Reference Group.** An Expert Reference Group comprising representatives from Disabled Peoples Organisations in Australia was established for the project. The reference group met six times over the life of the project and ensured the disability community had ownership of, and provided guidance on, all phases of the research project.

3. **Review of academic and grey literature.** To ensure inclusion of both multidisciplinary scholarship, as well as scholarship incorporating diverse research designs – including qualitative, quantitative, and mixed-method approaches – the research team sourced the academic and grey literature from:

   a. The leading generalist research databases, including EBSCO, Scopus, and ProQuest.

   b. Specialist research databases, such as ERIC (educational settings research), HeinOnline (legal research), and PsycINFO (behavioural and social science research).

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Limitations

The research team were provided with nine-months to complete the research project. Within this timeframe, it was not possible to conduct a new empirical study of the experiences of people with disability who have been subject to restrictive practices. Such studies require substantial time and planning, particularly to ensure ethical considerations are adequately addressed. The report instead drew on secondary empirical data about people with disability's experiences of restrictive practices collected from scholarly literature, reports and government inquiries.

Contemporary research into use of restrictive practices is marked by several limitations. These limitations shape the scope and limits of this report. There has been little scholarly research into the experiences of people with disability subject to restrictive practices in Australia. For this reason, the report includes experiences of people with disability who live in other, comparable countries. There has also been little to no research into the specific experiences of restrictive practices for LGBTQIA+ people with disability, or culturally and linguistically diverse people with disability. Only a few studies consider the experiences of First Nations people with disability. Additionally, while people with disability's experiences of some forms of restrictive practices are well explored – such as experiences of seclusion or involuntary mental health treatment – experiences of other forms of restrictive practice such as guardianship or financial management are rarely considered. This disparity in accounts is at least in part reflective of the opportunities that have and have not been provided to people with different types of disability to articulate experiences of restrictive practices over the years. Very few researchers venture into group homes to speak with people with disability, and, to the best of our knowledge, little to no attempts have been made to capture the accounts of people with disability subject to restrictive practices in the context of Australian Disability Enterprises, day programs, out-of-home-care, immigration detention, and in the family home. Each of these limitations within contemporary scholarship impact the ability of this report to respond with strong specificity in relation to relevant research questions set by the Disability Royal Commission about observed differences between types of disability, types of restrictive practice and/or types of setting. Further research will be required to address these areas of interest for the Disability Royal Commission.

Finally, there are also limitations inherent to contemporary research concerning strategies and approaches to reducing or eliminating restrictive practices. While there are a range of 'high-level' frameworks and principles for reducing and/or eliminating restrictive practices outlined for implementation in Australia across a range of different settings, including mental health settings, disability services settings and educational settings, there has been little to no research conducted to date on the effectiveness of these approaches. Moreover, where the question of effectiveness has been considered internationally, this has almost exclusively occurred in the context of mental health settings alone. Again, these limitations within contemporary scholarship on strategies for reducing and/or eliminating restrictive practices impact the ability of the report to respond with strong specificity in relation to relevant research questions set by the Disability Royal Commission about observed differences in effect between

different types of approaches, types of disability, types of restrictive practice and/or types of setting. Further research will also be required to address these areas of interest for the Disability Royal Commission.

Findings

Finding One: Restrictive practices are at odds with international human rights obligations

Use of restrictive practices is at odds with international human rights obligations for the treatment of people with disability. There is an absolute non-derogable prohibition on torture and cruel, inhuman or degrading treatment or punishment under international law. This means that restrictive practices that rise to the level of torture and cruel, inhuman or degrading treatment or punishment must be prohibited. Further, there are strong human rights obligations relating to prohibition of discrimination against people with disability and rights to protection from violence. In so far as restrictive practices represent a form of violence that is applied on a discriminatory basis to people with disability, then these practices, even where they do not rise to the level of torture and cruel, inhuman or degrading treatment or punishment, are at odds with international law.

Finding Two: Restrictive practices strip people with disability of dignity

The principle of dignity is at the core of international human rights obligations to prevent torture and ill-treatment, protections from violence, and equality and non-discrimination. Use of restrictive practices fails to respect the inherent dignity of people with disability. Analysis of the lived experiences accounts we collected shows that people with disability experience restrictive practices in the following, interconnected ways:

1. **Trauma, pain, harm and violation.** The report includes numerous accounts of people with disability speaking about their experiences of restrictive practices as physically painful, psychologically harmful and as a violation. For some people with disability, the trauma of restrictive practices intersects with, and is at times compounded by, other dynamics of oppression and injustice, such as settler colonialism and gender-based violence.

2. **Abandonment and neglect.** The report provides numerous examples of people with disability who were either left alone in seclusion without any supervision, or who had their experiences of distress and harm from restrictive practices ignored. The resulting effect of these experiences was people with disability feeling abandoned by those tasked with supporting them, and in turn helpless to improve their circumstances.

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3. **Fear.** Based on accounts examined in this report, many people who are subject to seclusion describe their experience of this as frightening. For some people with disability, this fear manifests from the brutality of their experience of seclusion and restraint itself, or from their experiences of abandonment. For others, the fear comes from a sense of not knowing what will happen next, and, importantly, not feeling safe enough in the setting to believe that what could happen next would be anything other than more harm.

4. **Disempowering, humiliating and dehumanising.** The report provides several examples of people with disability speaking directly to feelings of powerlessness in the context of restrictive practices. Some people with disability speak about powerlessness in terms of losing all control and having everything taken away. Others describe their experiences of powerlessness as amounting to a broader humiliation. Finally, some people with disability speak about their experiences of restrictive practices in terms of dehumanisation.

5. **Cruel and punishing treatment.** There are many examples in the report of people with disability describing being subject to restrictive practices who experience these as cruel a nd/or as punishment. Some people with disability are put in cages or are subject to experiences that make them feel as if they are being 'caged' and 'treated like an animal'. Several accounts provided in the report express a common rationalisation among some people with disability subject to restrictive practices: that 'I must have done something really wrong' to be punished with this form of treatment.'

6. **Lifelong trauma and life-altering effects.** Based on the accounts surveyed in this report, for some people with disability restrictive practices can have life-altering effects and contribute to lifelong trauma. Restrictive practices also fundamentally change how a person with disability may understand themselves and locate future meaning in their life.

Finding Three: Restrictive practice occur within an ecological system of violence, coercion and control

Restrictive practices take shape in an ecological system of violence, coercion and control. This ecological system extends out from individual people with disability, enveloping the person in concentric circles of relationships, institutions and social structures. The drivers and enabler of restrictive practices are located within this ecological system. The figure below illustrates the ecological system identified by this report.
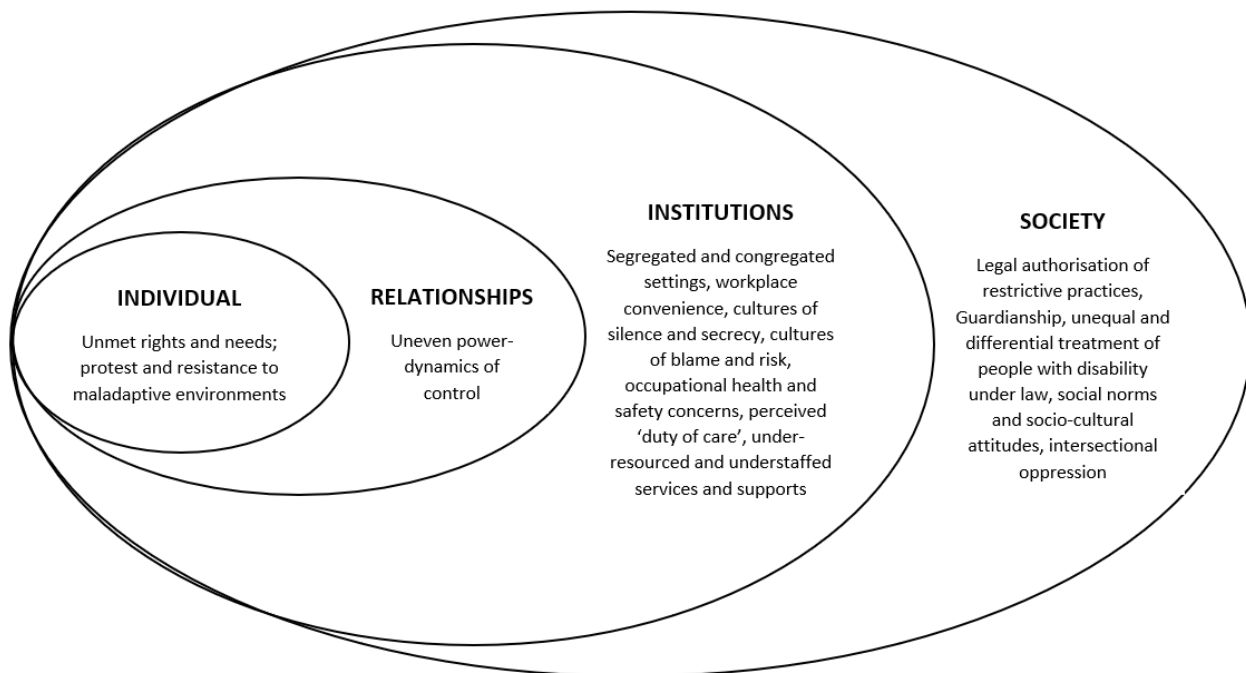
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Figure 1: The ecological system of restrictive practices as identified by people with disability

As the figure above illustrates, in the context of restrictive practices, our report found the ecological system of violence, coercion and control to include the following interconnected elements driving and enabling use of restrictive practices:

1. **'Individual' Considerations: Assumptions about 'behaviours of concern'.** Restrictive practices are often presented as a necessary response to an individual person with disability's perceived 'behaviours of concern'. The report shows that interactions commonly classified as 'behaviours of concern' are better understood as both 'adaptive behaviours to maladaptive environments',[1] and as communications of distress, protest and resistance in a historical context of vulnerability and dependency where others (i.e., service providers, teachers) are empowered to interpret the behaviours of people with disability as 'dangerous, frightening, distressing or annoying'.[2]

2. **'Relationship' Considerations: Uneven Power-dynamics of control.** Interacting with and extending from assumptions about 'behaviours of control' are the enveloping relationships between people with disability and those who are tasked with supporting them in a range of contexts and settings. The report shows how the use of restrictive practices breaks down relationships of trust between people with disability and those who are tasked with supporting them, as well as further entrenching already unequal power relationships.

3. **'Institutional' Considerations: Segregation, workplace concerns, and under-resourced sectors.** Relationships between people with disability and those tasked with supporting them take shape in institutional and organisational contexts. The research literature is

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unequivocal: people with disability are subject to the greatest use of restrictive practices in segregated and congregated contexts where people with disability are clustered together. Research suggests people with disability's lack of choice and autonomy within segregated and congregated settings is a distinguishing factor that contributes to the increased use of restrictive practices in these particular settings. Research also suggests that both within and beyond segregated and congregated settings, there are five core workplace concerns that appear to work both separately and together to drive use of restrictive practices:

a. Experience levels of staff. Research suggests that staff who have worked in their role for a long period of time are more likely to use restrictive practices against people with disability than staff who are less experienced in the role. Studies suggest that more experienced staff are often resistant to change, even after receiving contemporary training. This resistance to change can occur because staff express a preference to do things in the same way that they always have; staff hold beliefs that the old way of doing things is the best; and/or because of four other complex, workplace dynamics outlined separately below.

b. Institutional cultures of blame and risk management. One of the workplace dynamics that appears to inform and shape staff views about restrictive practices is an institutional culture of blame and risk management. Studies suggest a blaming culture within institutions and organisations can increase staff preoccupation with risk. This focus on risk can then contribute to persistent stigmatising beliefs about people with disability as inherently risky and/or dangerous. In many organisational settings, this persistent stigmatising belief typically centres around perceived 'behaviours of concern'.

c. Occupational health and safety concerns of staff. Australian research has identified a growing number of organisations which justify increased use of restrictive practices by reference to occupational health and safety concerns of staff. These concerns both emerge from, and play out within, a context where there are uneven power dynamics between those who 'work' and those who 'reside' in these formally administered settings. These uneven power dynamics set the scene for the occupational health and safety concerns of staff to be prioritised over the rights of people with disability in these settings.

d. Staff perceptions about their 'duty of care' obligations. A duty of care is a legal obligation to avoid doing things that could foreseeably cause harm to another person. Research suggests staff may work with vague or incorrect proximations of duty of care obligations. Restrictive practices may therefore be used as a mechanism by staff to avoid perceived situations of harm where staff believe they could be held legally liable if they do not take action.

e. Under-resourced services and supports for people with disability. Research suggests there is an association between the resourcing of the workplace, staff perceptions of safety, and staff attitudes towards and use of restrictive practices for the purposes of maintaining a 'safe' environment. In practice this can mean that some staff may use restrictive practices as one of the primary tools via which they can negotiate the broader structural and economic issue associated with an under-resourced and understaffed disability sector.

Notably, restrictive practices are also often shrouded by institutional cultures of silence. These cultures see the actions of staff that occur in the workplace – including decisions to use restrictive practices as a matter of convenience or control – not being discussed with the person with disability nor anyone else external to the organisation.

4. **'Societal' Considerations: Enveloping social norms and enabling laws.** Ableist views towards people with disability position people with disability as lesser than and naturally unequal to people without disability. These views legitimate beliefs that people with disability can and should be subject to violent and coercive forms of intervention that would not be tolerated in relation to people without disability. Research suggests ableist views can often be disguised in the service and support sector as benevolence; as a 'commitment to care', or well-intended 'protection' for people with disability. For some people with disability, use of restrictive practices is further shaped and rationalised by other forms of prejudice and discrimination, including racism and sexism.

Currently, there are few, if any, consequences for staff who use restrictive practices against people with disability. This is because, currently, restrictive practices are permitted and regulated via law and policy. This permission sustains institutional cultures of silence, and further enforces the unequal power relationships between people with disability and service providers. Ultimately, law enables use of restrictive practices by not holding those who use them to account, and by denying redress to those who are subjected to them.

Finding Four: Positive behaviour support has a mixed and inconclusive evidence-base

Several current national frameworks or principles for reducing and/or eliminating restrictive practices emphasise investment in positive behaviour support (PBS). The report provides a review of scholarly national and international literature on PBS. This review produced five core findings:

1. **An evidence-base with distinct limitations.** Many studies of the effectiveness of PBS are based on very small sample sizes. Moreover, much of the PBS evidence-base raises questions about the strength, accuracy and integrity of the findings. These limitations have led some researchers to classify this evidence-base as 'emerging' and not established.

2. **A focus on staff training.** The evidence-base for PBS is characterised by a focus on staff training. This focus appears to be underpinned by an assumption that there is a connection between staff training and positive outcomes for people with disability, in particular, improved quality of life. This assumed connection is both infrequently studied, and on the rare occasion it has been studied, does not prove true.

3. **A focus on the quality of plans, which prove to be poor quality.** There appears to be a belief that better staff training and knowledge of PBS will lead to better behaviour support plans being developed for people with disability. These better plans are then assumed, again, to lead to positive outcomes for people with disability. Studies of behaviour support plan quality typically find behaviour support plans to be of 'poor' or 'remarkably low' quality.

4. **Mixed and inconclusive results about the overall effectiveness of PBS.** There are mixed or inconclusive findings about the overall effectiveness of PBS. Some studies note positive outcomes. Some studies find positive effects in relation to some elements, but not others. Other studies draw inconclusive findings or findings of no effect.

5. **The relationship between the environment and the person.** In studies that provided details about the nature of the 'intervention' that took place to produce a positive outcome, what appears to have changed is the quality of the environment and service being provided to the person with disability. Positive outcomes appear to occur for people with disability when: (a) staff are nonconfrontational and consistent in their communication with the person with disability; (b) staff do not impinge on the autonomy of the person with disability; (c) people with disability are enabled to participate in meaningful activities of their choosing; and (d) the wishes of the person with disability are listened to and acted upon. Such findings are consistent with the understanding that perceived 'behaviours of concern' are distress, protest and resistance made in a context of maladaptive 'environments of concern'. These findings also raise important questions about the standards and quality of contemporary disability services and supports.

Case examples of evaluated approaches to reducing restrictive practices

Three key international approaches to reducing restrictive practices have been studied, and have had some success in reducing restrictive practices. These three examples have been adopted by several countries over the years, including, in two of the cases, Australia. The examples are:

1. **The 'No Force First Project': England.** The No Force First project works from the proposition that effective recovery for people receiving services requires enabling people's 'choice, self-determination, and personhood.'[3] Within this context, any form of force or coercion is understood to ultimately undermine the person's recovery. Studies of the No Force First approach have shown reductions in seclusion and physical and chemical restraint in both general mental health wards, mental health crisis services, and forensic mental health wards. The No Force First approach has also been used in the context of forensic learning disability wards with some success. However, an evaluation found that there was a significantly higher prevalence of physical restraint and harm in forensic learning disability wards as compared to forensic mental health wards, with this difference remaining post-introduction of the No Force First approach.[4]

2. **Six Core Strategies to Reduce Seclusion and Restraint Use: USA.** The Six Core Strategies propose a trauma-informed approach to services. The strategies can be summarised as: (1) leadership towards organisational change; (2) use of data to inform practice; (3) workforce development; (4) use of seclusion and restraint prevention tools; (5) consumer roles in inpatient settings; and (6) debriefing techniques. Studies of the Six Core Strategies approach have shown reductions in restraint and seclusion in

specialised mental health organisation, general mental health wards, and adolescent psychiatric hospitals. Recently, the Six Core Strategies was adapted as part of the 2019 Australian College of Mental Health Nurses, *Safe in Care*, *Safe at Work Toolkit* for use in Australian mental health contexts. The *Toolkit* has not been formally evaluated at this time.

3. **The 'Safewards' Model: England.** Safewards is a clinical model for the management of conflict in mental health settings. The Model was originally developed as a tool to create a safer environment for both staff and patients. While the Safewards Model includes consideration of restrictive practices use, the model has a broader focus on understanding conflict, its causes, and staff responses to it. The Safewards Model has shown some positive effects in the context of general mental health settings. Evaluations of the model in other settings have provided mixed results. The Safewards Model has been implemented in a range of different jurisdictions around the world, including in the Australian states of Queensland, New South Wales and Victoria. Evaluations of the Model in these Australian jurisdictions provides mixed results.

Recommendations

The report demonstrates how restrictive practices occur within, and are driven by, an extending and encompassing ecological systemic system of violence, coercion and control. To eliminate restrictive practices, it is recommended that governments of Australia work through this ecological system in reverse order. By addressing elements present in the outer circles of the ecological system first, elements identified in the inner circles may become easier to address, or may no longer be apparent. The report proposes an eight-point action plan for eliminating restrictive practices. The box below outlines the plan, distinguishing between the 'society', 'institutional', 'relationships', and 'individual' elements of the ecological system of violence coercion and control.

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Eight-point action plan to eliminate restrictive practices

SOCIETY

1. **Prohibit Restrictive Practices**

End legal authorisation for use of restrictive practices

2. **Change Attitudes and Norms**

Support awareness raising to address discriminatory attitudes and norms

3. **Acknowledge and Address Historical Injustice**

Publicly acknowledge past wrongs, support truth telling

INSTITUTIONS

4. **Deinstitutionalise and Desegregate**

Deinstitutionalise and desegregate environments

RELATIONSHIPS

5. **Recognise the Autonomy and Leadership of People with Disability**

Support exercise of legal capacity

6. **Utilise Trauma Informed Support Approaches**

Reform service systems to recognise and respond to people with disability using trauma informed approaches

INDIVIDUAL

7. **Adequately Resource Independent Living and Inclusion**

Fully resource and realise Article 19 CRPD rights to independent living and inclusion

8. **Provide Redress for Victim-Survivors**

Seek to rectify injustice through law reform and a national redress scheme

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Recommendation 1: Prohibit restrictive practices.

It is recommended governments in Australia impose an immediate legal prohibition of use of restrictive practices on a discriminatory basis against people with disability. This recommendation is consistent with obligations under international law, the rights and dignity of people with disability, and established violence prevention principles that have been operationalised in relation to other marginalised populations.

Recommendation 2: Change social attitudes and norms related to people with disability.

It is recommended governments in Australia invest in strategies to change the socio-cultural attitudes and norms driving restrictive practices. The Convention on the Rights of Persons with Disabilities (CRPD) places clear obligations under Article 5, 12 and 13 to prohibit discrimination and ensure equality before the law and equal access to justice. The CRPD further stresses that people with disability are owed equal rights to protection from violence, as articulated by Articles 14-17. Steps taken to change socio-cultural attitudes and norms are consistent with 'awareness raising' obligations described by Article 8 CRPD, which extend to activities by States and society to 'combat stereotypes, prejudices and harmful practices relating to persons with disabilities.'

Recommendation 3: Acknowledge and address historical and ongoing injustice associated with use of restrictive practices.

Elimination of restrictive practices will require commitment to a process which acknowledges that society and law have perpetrated a historical and ongoing injustice against people with disability. It is recommended governments in Australia invest in structural responses of truth and repair in relation to those who have experienced restrictive practices. These structural responses must engage professions (e.g., medical, health, education, social work and law), services and the broader public in learning about the harms and injustices of restrictive practices, and in reckoning with, and being accountable for, meaningful change.

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Recommendation 4: Deinstitutionalise and Desegregate.

It is recommended that governments in Australia commit to *full* deinstitutionalisation and desegregation of the living environments of people with disability. Research indicates that to facilitate full deinstitutionalisation of people with disability, there must be a commitment to deinstitutionalisation, a change in attitudes towards people with disability, community development that enables full inclusion and participation of people with disability, as well as a rights-based and transformative policy shift towards housing.

It is further recommended that governments address segregation of environments beyond housing that people with disability also find themselves within. This means ending segregation in systems that currently only apply to people with disability such as 'special' or segregated schools, Australian Disability Enterprises (ADEs), group homes, day centres, and mental health facilities. Ending segregation of people with disability would align with violence prevention and safety enhancement approaches identified in the Royal Commission into Institutional Responses to Child Sexual Abuse.

Recommendation 5: Recognise the autonomy of people with disability.

It is recommended that governments in Australia respect and protect the autonomy of people with disability to make decisions about what happens to their bodies and lives. This recommendation for autonomy is consistent with obligations outlined in the CRPD, particularly Article 12 on equality before the law, and Article 19 on independent living and community inclusion, as well as Article 21 on freedom of expression and opinion, Article 29 on participation in political and public life, and general principles in Article 3. Enhancing the autonomy of people with disability in relation to First Nations people with disability needs to be understood in the broader context of Indigenous and First Nations self-determination and nation-building.

Recommendation 6: Utilise trauma-informed support approaches.

Restrictive practices are traumatic. It is recommended that governments in Australia facilitate trauma-informed approaches to service-delivery, particularly within the human services sector. This recommendation is consistent with the obligations outlined in Article 16 of the CRPD.

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Recommendation 7: Adequately resource independent living and full inclusion

The report recommends adequate resourcing for realising people with disability's rights to independent living and full inclusion, as well as economic, social and cultural rights. Article 19 CRPD provides a clear vision for enabling independent living and community inclusion for people with disability. This Article interconnects with economic, social and cultural rights, including rights to education, health, housing and social security. Realising these rights of people with disability will help to reduce or remove the circumstances of inequality, control, coercion, segregation, and confinement that are drivers of and form part of the ecological system of restrictive practices, and enhance their overall status in society.

Recommendation 8: Provide redress for victim-survivors.

The elimination of restrictive practices requires commitment to a process which acknowledges that society and law have perpetrated a historical injustice against people with disability. This extends to providing forms of just rectification, including redress for victim-survivors. It is recommended governments of Australia invest in redress options for victim-survivors of restrictive practices.

There are two different approaches to supporting access to redress – first, through the criminal and civil justice systems, and second through a proposed national redress scheme. For people with disability, a redress scheme can potentially be more accessible, affordable and efficient than court litigation. A redress scheme is also capable of making redress available to a larger group of individuals (including those who have experienced lawful restrictive practices or historical restrictive practices), and is not dependent on the present-day existence and/or wealth of the perpetrators. From a human rights perspective, a redress scheme is particularly significant because it can redress all human rights violations irrespective of whether they were unlawful under domestic law. A redress scheme should operate alongside court remedies, and access to one should not prevent access to the other. Attention must also be paid to improving access to justice in the criminal and civil justice systems for victim-survivors of restrictive practices.

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