RETHINKING RESTRICTIVE PRACTICES: A COMPARATIVE ANALYSIS

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This paper undertakes the first comparative analysis of restrictive practices legislation in Australia. This legislation, which regulates practices used to manage 'challenging behaviours' of people with intellectual disability or cognitive impairment, currently exists in four Australian jurisdictions. The paper demonstrates the gaps in coverage of this legislation and the wide variation of law nationally. We argue that legislation governing restrictive practices is needed, it should regulate the provision of all restrictive practices (not just some) and that there should be a national consistent approach.

I INTRODUCTION

Every day, thousands of people with an intellectual disability or cognitive impairment around the country are subject to disturbing practices such as physical restraint, seclusion in rooms, confinement in their homes, placement in splints or body suits to restrain them, and administration (without their consent) of psychotropic medication to sedate them and make them more compliant.[1] These 'restrictive practices' are used in response to what is known as 'challenging behaviours' exhibited by people with intellectual disability or cognitive impairment in a variety of settings including disability services, hospitals, aged care facilities and rehabilitation services. Emerson describes challenging behaviour as 'culturally abnormal behaviour(s) of such intensity, frequency and duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit the use of or result in the person being denied access to ordinary community facilities'.[2] Until relatively recently, restrictive practices to manage so-called 'challenging behaviours'[3] have occurred behind closed doors: unseen, unsupervised and unmonitored.

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[1] Disability Rights Now, *Australian Civil Society Parallel Report Group Response to the List of Issues* (CRPD 10th Session Dialogue with Australia, Geneva, September 2013).

[2] Eric Emerson, *Challenging Behaviour, Analysis and intervention in people with severe intellectual disabilities* (Cambridge University Press, 2nd ed, 2001).

[3] See below Part V(B) ('Preventing Harm') for the discussion where the use of this term is critiqued.

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But the past decade has seen increased public and policy awareness of this issue in Australia. For example, in his 2006 report *Challenging Behaviour and Disability: A Targeted Response*, the Honourable WJ Carter QC drew attention to the continuing over-reliance by disability service providers in Queensland on practices such as the use of detention, restraint and seclusion and the significant impact this has on the human rights of people with disability.[4] He also raised doubts about the lawfulness of such practices. Carter, like the Victorian Law Reform Commission report delivered three years earlier,[5] recommended a legislative framework to regulate restrictive practices. This was considered crucial to establish sufficient safeguards to ensure the use of restrictive practices was subject to independent approval, review and monitoring, and accompanied by a behavioural support approach that was focused on improving the quality of life for the person whose liberty was stake.

The regulation of the use of restrictive practices on people with intellectual disability and cognitive impairment is in its infancy in Australia. Specific legislation has been enacted only in Victoria, Queensland, Tasmania and the Northern Territory. However, even in these jurisdictions, this legislation applies only to the use of restrictive practices in state government provided or funded disability services. This means that in the four jurisdictions that have enacted legislation, restrictive practices used in privately provided services or in hospitals, aged care and other health facilities are not specifically regulated. And in the four jurisdictions that have not enacted legislation, the use of restrictive practices is not specifically regulated at all.

Where there is no specific legislative framework that regulates restrictive practices (either because there is no legislation in the jurisdiction or because the legislation does not apply to the particular setting being considered), it may be the practice to rely on guardians to consent to the detention and restraint of people with intellectual disability and cognitive impairment. However, the lawfulness of many of these practices is doubtful, with health professionals and service providers potentially exposed to civil and criminal liability.[6] And more importantly, the absence of a specific legislative framework means there is little transparency in decision-making

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4 William Carter QC, *Challenging Behaviour and Disability: A Targeted Response* (Report to Warren Pitt MP, Minister for Communities, 2006).

5 Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care*, Report (2003).

6 Any medical treatment (including the use of medication) or physical restraint will, when applied without consent (or other lawful authorisation) to a person with intellectual impairment, constitute trespass at common law (*Department of Health and Community Services v JWB & JWB & SMB* [1992] HCA 15; (1992) 175 CLR 218 (Marion's Case)), or assault under section 245 of the *Criminal Code 1899* (Qld). Whether a guardian can lawfully consent to the use of medication to control behaviour or physical restraint will depend on the nature of the guardian's appointment and the practice that the health professional seeks to use as well as the specific guardianship legislation. Guardianship tribunals have expressed doubt about whether guardians can consent to the use of certain restrictive practices. For example, in *Re AAG* [2009] QGAAT 43 the Queensland Civil and Administrative Tribunal characterised as 'unresolved' the question as to whether a guardian for health care or a guardian for personal matters could lawfully consent to the administration of medication (the drug Androcur) constituting a restrictive practice.

about restrictive practices, and few safeguards such as independent review and monitoring.

The development of legal responses to regulate restrictive practices comes at watershed time in Australia's history in terms of funding services for people with intellectual disability or cognitive impairment. The National Disability Insurance Scheme ('*NDIS*') is predicated on a system of choice and control. Services and supports provided to people with disability will be directed by people with disability themselves. They will be able to choose to purchase their own services that are 'reasonable and necessary'[7] from a wide range of service providers. This approach is consistent with a rights-based and person-centered approach to disability services.

Given that state governments will step back from the role of providing disability services, or funding non-government organisations to provide these services, the question arises about the maintenance of safeguards for people with disability as many more enter the private sector. Safeguards are important to help reduce risk of abuse, neglect and exploitation of people with disability and to ensure the safety and quality of services. This shift in approach to disability funding has significant implications for the utility and reach of the current regulatory frameworks governing restrictive practices as they apply only to *state government provided or funded disability services*. As such, these laws will not apply to the direct purchase of services by people with disability that are not funded or provided by state human services departments, as is contemplated by the NDIS.

While the Commonwealth, State and Territory Governments have developed the *National Framework for Reducing the Use of Restrictive Practices* outlining the 'key principles to guide work in this area and core strategies to be implemented to reduce the use of restrictive practices in the disability service sector',[8] a uniform regulatory approach has not been endorsed by Commonwealth, State and Territory Governments at this stage.

Other key developments in Australia include that the Australian Law Reform Commission ('*ALRC*') has recommended that the Australian Government and Council of Australian Governments ('*COAG*') develop a national or nationally consistent approach to the regulation of restrictive practices as part of its inquiry into equal recognition before the law and legal capacity for people with disability.[9]

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7 *National Disability Insurance Scheme Act 2013* (Cth) s 34.

8 Department of Families, Housing, Community Services and Indigenous Affairs, *Draft Proposed National Framework for Reducing the Use of Restrictive Practices in the Disability Service Sector* <www.fahcsia.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/draft-proposed-national-framework-for-reducing-the-use-of-restrictive-practices-in-the-disability-service-sector> (accessed 19 November, 2013).

9 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws: Issues* Paper, Issues Paper No 44 (2013) 82; Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Discussion Paper No 81 (2014) ch 8.

And internationally, the *Convention on the Rights of Persons with Disabilities*,[10] and particularly Article 12 dealing with legal capacity, raises important questions of how nations regulate restrictive practices. How does the authorisation of practices such as detention, restraint and seclusion fit with the increasing emphasis on maximising the autonomy and self-determination for people with disability and providing support for them to make their own decisions?

The United Nations Committee on the Rights of Persons With Disabilities ('*UNCRPD*') has expressed concern about the unregulated use of restrictive practices in Australia. In the concluding observations on Australia's initial report under the *Convention on the Rights of Persons with Disabilities*, the UNCRPD stated that:

> The Committee is concerned that persons with disabilities, particularly those with intellectual impairment or psychosocial disability, are subjected to unregulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraint and seclusion, in environments including schools, mental health facilities and hospitals.[11]

As such, this paper deals with a pressing human rights issue that Australia governments are grappling with – or need to. It begins by briefly outlining the two key reports, one in Victoria and one in Queensland, which provided the impetus for reform in those jurisdictions. The paper then engages in the first comparative analysis that has been undertaken of the various restrictive practices legislation in the four states that have it. The analysis considers the model of regulation adopted – administrative or guardianship – and the varying nature of the restrictive practices regulated. It also examines the different criteria that need to be met for restrictive practices to be used and the safeguards designed to promote good decision-making and limited use of such practices. The paper concludes, drawing on this comparative analysis, by identifying issues for governments to consider when making decisions about regulating the use of restrictive practices for people with intellectual disability and cognitive impairment.

II BACKGROUND TO LEGISLATIVE REFORM

Two major reports, one by the Victorian Law Reform Commission ('*VLRC*') in 2003,[12] and the other by the Honourable WJ Carter QC in Queensland in 2006,[13] are widely regarded as being the impetus for legislative reform in this field. Both inquiries highlighted the lack of transparency in relation to the use of detention of people with disability who had not been convicted of a criminal offence (civil detention) and restrictive practices such as restraint and seclusion. The limited

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[10] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007 [2008] ATS 12 (entered into force 3 May 2008) ('*Convention on the Rights of Persons with Disabilities*').

[11] Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia* (adopted by the Committee at its tenth session 2-13 September 2013) 5.

[12] Victorian Law Reform Commission, above n 5.

[13] William Carter QC, above n 4.

safeguards, oversight and review of the use of these practices were also the subject of criticism, as was the questionable lawfulness of such practices.

A Victorian Law Reform Commission Report

In its inquiry into the compulsory care of people with intellectual disability, the VLRC drew attention to the fact that people with intellectual disability were being detained other than for the commission of a criminal offence. This detention occurred in two circumstances: some people may have originally been sentenced for a serious criminal offence, then continued to be held in a secure facility even after the expiration of their sentence; and other people with disability, not charged with a criminal offence, but whose behaviour was thought to seriously endanger others who were held in secure facilities. In both situations, it had been the practice either to rely on the authorisation of guardians for their detention or the 'consent' of those detained, both of which were legally problematic.[14]

With regards to the use of restrictive practices such as restraint and seclusion, the VLRC found that while some controls on the use of these practices had been imposed by the *Intellectually Disabled Persons Services Act 1986*,[15] these were not sufficient. In particular, there was thought to be insufficient safeguards for the use of restrictive practices, including a lack of adequate monitoring or review.[16]

The VLRC Report, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care*,[17] recommended key characteristics of two separate legislative frameworks: one for detention of people with intellectual disability who exhibit behaviours that may seriously harm others (civil detention); and a separate regime for restraint and seclusion (or restrictive practices) when they are used in relation to people with intellectual disability.[18]

In relation to restrictive practices, the VLRC emphasised the importance of a transparent process for regulating practices such as restraint and seclusion so that there would be external scrutiny of their use as well as a regulatory regime with clear criteria, a process for approval of behaviour support plans, monitoring and review.[19] The VLRC also recommended the establishment of an independent statutory position, known as the Senior Clinician,[20] whose role it would be to oversee both the detention of people with intellectual disability and the use of restrictive practices. It was also recommended that the Senior Clinician should have the role of approving the inclusion of restraint and seclusion in behaviour support plans.[21]

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14 Victorian Law Reform Commission, above n 5, 49-50.
15 *Intellectually Disabled Persons Services Act 1985* (Vic) s 44.
16 Victorian Law Reform Commission, above n 5, xvii.
17 Victorian Law Reform Commission, above 5.
18 Ibid 87-112.
19 Ibid 91.
20 Ibid 55.
21 Ibid 105.

An independent Tribunal, such as VCAT, comprised of expert members, was recommended by the VLRC to authorise and review civil detention.[22] The VLRC was adamant that it was no longer appropriate for guardians to authorise the detention of people with intellectual disabilities or cognitive impairments, stating that…

> …. guardians should not be able to consent to a person being detained in a secure facility. Generally, the law does not allow detention of people because there is a risk that they may harm others. Because detention without the detainees' consent of people who have not been convicted of a criminal offence is a very severe restriction on their liberty, it is in the interests of the community as a whole that such decisions should be made in accordance with transparent criteria and should be open to scrutiny and monitoring. The guardian of a person with a mental illness cannot consent to that person's involuntary detention or treatment. It is therefore anomalous that people with an intellectual disability or cognitive impairment are not similarly protected.[23]

B The Carter Report

Two and a half years after the VLRC Report was released, Carter led an inquiry in Queensland into the systemic service delivery issues for people with intellectual and cognitive disability and challenging behaviours who had been subjected to a range of restrictive practices. This cohort of people included those subject to civil detention. His report, *Challenging Behaviour and Disability: A Targeted Response* (the '*Carter Report*'),[24] identified an over reliance on the use of restrictive practices by service providers and pointed to need for 'a fundamental process of reform, renewal and regeneration'.[25] He also drew attention to the potential for civil and criminal liability for service providers who detained or otherwise restrained people without lawful authority.[26] A new legislative regime for restrictive practices was but one recommendation in the Carter Report that focused more broadly on the need for a significant service system reform.

Carter expressed some misgivings about the Victorian model that separated the regulation of detention from restrictive practices. He was concerned that this model of regulating detention could lead to more people with disability living in institutional type environments, whereas many people with disability who lived in secured environments, were currently living in 'home like' environments in the community.[27] Therefore, the Carter Report ultimately recommended a legislative framework for restrictive practices inclusive of civil detention. The Carter Report emphasised the importance of the decision maker being independent from the service provider, or the department that funded the services; as well as the decision making body being both accessible and having the relevant expertise. The Queensland Guardianship and Administration Tribunal, as it then was, was suggested (now the Queensland Civil and Administrative Tribunal).

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22 Ibid 62.
23 Victorian Law Reform Commission, above n 5, 24.
24 William Carter QC, above n 4.
25 Ibid 9.
26 Ibid 147.
27 Ibid 164-5.

While Carter did not recommend a Senior Clinician role, there was an emphasis on the importance of clinical expertise in the proposed regime, with a Queensland Centre for Best Practice in Positive Behaviour Support proposed, under the leadership of a highly regarded practitioner.[28]

The respective reports, the VLRC Report and the Carter Report with their different emphases and recommendations, influenced the respective regulatory responses in Victoria and Queensland. While the legislative regimes ultimately enacted differ in some significant ways (explored later in this article), both establish safeguards and independent oversight of the use of practices such as detention, seclusion and restraint of vulnerable people with intellectual disability and cognitive impairment.

III NATURE AND SCOPE OF RESTRICTIVE PRACTICES REGULATORY REGIMES

Victoria, Queensland, Tasmania and the Northern Territory currently specifically regulate the use of restrictive practices in their disability legislation (see Table 1).[29] In 2012 and 2013 respectively, South Australia and New South Wales reviewed their disability legislation, and consulted on whether legislative provisions for restrictive practices should be introduced.[30] No legislative reform has occurred to this date in those two jurisdictions, nor in Western Australia or the Australian Capital Territory.[31]

In Victoria, the *Disability Act 2006* regulates the use of restrictive practices. Part 7 of the Act, regulates what is called 'restrictive interventions' which constitutes restraint (chemical restraint and mechanical restraint) and seclusion. In Queensland, the regulatory framework for the use of 'restrictive practices' is contained in Part 6 of the *Disability Services Act 2006*, and Chapter 5B of the *Guardianship and Administration Act 2000*. Part 6 of Tasmania's *Disability Services Act 2011* regulates the use of 'restrictive interventions', which are defined as 'environmental restrictions' and 'personal restrictions'. Finally, Part 4 of the Northern Territory's *Disability Services Act* regulates 'restrictive interventions'. The nature of these restrictive practices or interventions is discussed further below.

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28 Ibid 16.

29 *Disability Act 2006* (Vic); *Disability Services Act 2006* (Qld); *Disability Services Act 2011* (Tas); *Disability Services Act* (NT). In Queensland, the *Guardianship and Administration Act 2000* (Qld), Chapter 5B, also regulates the use of restrictive practices.

30 Department for Communities and Social Inclusion, *New Disability Legislation for South Australia: Final consultation paper seeking views of people with a lived experience of disability* (Government of South Australia, 2012); New South Wales Government, *Reforming NSW Disability Support: Legislative structure and content: discussion paper* (January 2013).

31 While the Disability Inclusion Bill 2014 (Public Consultation Draft, New South Wales Government, 2014) contained provisions that regulated restrictive practices, these were not included in the final *Disability Inclusion Act 2014* (NSW). The South Australian *Disability Services Act 1993* was amended in December 2013 to require service providers to have in place policies and procedures for ensuring the safety and welfare of persons using disability services, which may include policies and procedures for restrictive practices.

Table 1: Jurisdictions that regulate restrictive practices and relevant legislation

	VIC	QLD	TAS	NT
Date commenced	1 July 2007	1 July 2008	1 January 2012	20 August 2012
Relevant Act/s	*Disability Act 2006*	*Disability Services Act 2006* *Guardianship and Administration Act 2000*	*Disability Services Act 2011*	*Disability Services Act*
Regulates	Restrictive interventions	Restrictive practices	Restrictive interventions	Restrictive interventions

A Focus on state-funded and provided disability services

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

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

[32] Under section 14(c) of the *Disability Services Act 2011* (Tas), grants of funding may be provided both to a person or an organisation to provide disability services or to a person, or another person nominated by a person with a disability to enable the provision of disability services (a funded private person is defined in s 14(c)). The restrictive practices regulatory regime applies to both (s 36(1)).

B Administrative versus guardianship models

There are two distinct models utilised in restrictive practices legislative regimes – an administrative and a guardianship model (see Table 2). An administrative model relies on an existing administrative decision-maker, such as the secretary or chief executive officer of the department in which the services are provided or funded, to approve or authorise the use of restrictive practices. Other models utilise the existing guardianship system in the relevant jurisdiction, where guardians (who may be the Public or Adult Guardian, or family members or friends appointed as a guardian) give consent to the use of restrictive practices. Sometimes a guardianship tribunal (or the generic civil and administrative tribunal with guardianship jurisdiction) might make certain decisions. This model is akin to a substitute decision-making model, where restrictive practices are treated as another type of decision, like personal or health decisions, that a guardian makes on behalf of a person with impaired decision-making capacity.

Within the context of the current restrictive practices regimes, most restrictive practices are approved by an administrative decision maker, such as the secretary or chief executive office of the relevant state's human services department or a senior officer in a disability service. The administrative model fits well with the overall objective of the regulatory regimes that are aimed at regulating the standards of care provided in state funded disability services; in that it enables the respective human services departments to maintain greater control over the delivery of support services in state-funded or provided disability services.

Victoria was the first jurisdiction to regulate restrictive practices and adopted the administrative model. Where restrictive practices are proposed to be used by non-government service providers funded by the government to deliver disability services, the service provider must first be approved by the secretary of the department to use restrictive practices.[33] Authorised program officers, senior positions in service providers' organisations, then approve the inclusion of restrictive practices in a person's behaviour support plan.[34] Where government operated disability services use restrictive practices, approval is not required as such, but certain requirements must be met to lawfully use restrictive practices, including the appointment of an authorised program officer who has responsibility for approving the inclusion of restrictive practices in a person's behaviour support plan.[35]

In contrast, Queensland has a predominately guardianship model. This model reflects the emphasis in the Carter Report on the importance of the independence of the decision-maker from the service provider seeking to use restrictive practices. Carter had recommended the Guardianship and Administration Tribunal ('*GAAT*') to approve restrictive practices. Ultimately GAAT (whose jurisdiction was subsumed into the Queensland Civil and Administrative Tribunal ('*QCAT*') in 2009) became a

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33 *Disability Act 2006* (Vic) s 135.
34 Ibid s 145(1).
35 Ibid s 135(4).

decision-maker for containment and seclusion,[36] as well as the body that appointed guardians for other restrictive practice matters. These appointed guardians are then authorised to consent to the use of restrictive practices, other than containment and seclusion.[37]

Tasmania has a 'hybrid' approach, combining elements of both models with the secretary of the department approving 'environmental restrictions'[38] while the Guardianship and Administration Board approved 'personal restrictions' (such as physical restraint).[39]

In the Northern Territory, the regulatory regime for restrictive practices only applies to persons who reside in residential facilities operated by the agency (the Aged and Disability Program, in the Department of Health) responsible for disability services.[40] This is an administrative model and the Chief Executive Officer, who proposes to use the restrictive practices, must be satisfied that certain requirements are met in order for restrictive practices to be lawfully applied.[41]

Table 2: Models of decision making for restrictive practices regulatory regimes

Model	VIC	QLD	TAS	NT
Administrative	The secretary of the department approves the service provider to use restrictive practices, while an authorised program officer[42] approves the inclusion of restrictive practices in the behaviour support plan		The secretary of the department (environmental restrictions)	The chief executive officer

36 *Guardianship and Administration Act 2000* (Qld) s 80V.

37 Ibid s80ZE. While Queensland has a predominately guardianship decision-making model, it also has the most complex decision-making model. There are potentially five different decision makers depending on the type of practice authorised, the setting in which it is used and whether it is for general or short term use. In addition to QCAT and guardians for restrictive practice matters, short term approval is provided by either the chief executive or the Adult Guardian, and informal decision makers may be decision makers in community access and respite services for some practices.

38 *Disability Services Act 2011* (Tas) s 38.

39 Ibid s 42. The Guardianship and Administration Board may also approve 'environmental restrictions': *Disability Services Act 2011* (Tas) s 42.

40 Northern Territory, *Disability Services Amendment Bill Second Reading Speech*, Legislative Assembly, 2012 (Mr Vatskalis MP, Minister for Health).

41 *Disability Services Act* (NT) ss 37, 41(2).

42 A senior officer in the disability service using the restrictive practices.

Model	VIC	QLD	TAS	NT
Guardianship		QCAT (containment and seclusion); Restrictive practice guardians (other restrictive practices)	The Guardianship and Administration Board (personal restrictions)	

IV RESTRICTIVE PRACTICES REGULATED

While there is some variation across the jurisdictions, the restrictive practices that are most commonly regulated are seclusion and physical, mechanical and chemical restraint. Civil detention (or 'containment', as it is called in Queensland) is sometimes regulated as a restrictive practice, but more often under distinct involuntary treatment regimes. This section will consider the restrictive practices regulated in each jurisdiction, as well as the different approaches taken to the detention of people with intellectual impairment in disability services. Table 3 provides an overview of the different forms of restrictive practices and how they are regulated or described in the various jurisdictions.

Table 3: Nature of restrictive practices and how regulated and described by jurisdiction

Nature of restrictive practice	VIC	QLD	TAS	NT
Physical restraint	As an 'other restrictive intervention'	As 'physical restraint'	As a 'personal restriction'	As 'physical restraint'
Mechanical restraint	As 'mechanical restraint'	As 'mechanical restraint'	As a 'personal restriction'	Not regulated
Restricting access	As an 'other restrictive intervention'	As 'restricting access to objects'	As an 'environmental restriction'	As 'restricting access'
Chemical restraint	As 'chemical restraint'	As 'chemical restraint'	Not regulated	As 'chemical restraint'
Seclusion	As 'seclusion'	As 'seclusion'	As a 'personal restriction'	As 'seclusion'

Nature of restrictive practice	VIC	QLD	TAS	NT
Detention/ containment	Not as a restrictive intervention but compulsory treatment.	As 'containment'	As a 'personal restriction'	Not as a restrictive intervention but involuntary treatment.

A Detention [regulated as a restrictive practice or involuntary treatment]

Civil detention (or 'preventative detention', as it sometimes known as) describes the detention of someone other than in connection with an alleged criminal offence. Rather, the purpose of the detention is to prevent the person from causing harm to themselves or others.

Containment, as the practice is referred to in Queensland, refers to preventing an individual from leaving premises, and the following example is provided from a Queensland government publication:

> Ken is a 35-year-old man with an intellectual disability who lives in his home with support staff. Ken has been known to leave his home without support staff and will try to take soft drinks from the local shop. When the shopkeeper tries to stop Ken he gets upset and hits the shopkeeper, leaving him hurt. Support staff now keep the front door to his home locked to stop Ken from freely leaving his home without support staff and preventing Ken from harming the shopkeeper.[43]

Under Queensland legislation, to 'contain' an adult means to 'physically prevent the free exit of the adult from premises where the adult receives disability services'.[44] Unlike the other jurisdictions, Queensland expressly regulates detention as a restrictive practice and detention (or containment) as it is known, must be approved by QCAT. In *MJI,*[45] the Tribunal described the following environment of MJI, a 23-year-old man with intellectual disability and autism, for whom containment had been approved, and in the Tribunal's words lived in 'prison-like' conditions:

> His physical environment is appalling. It is almost totally devoid of any furniture. It is poorly maintained, barren, and lacks any personalised comforts or items. MJI generally receives his meals through a slot. He watches television by having the image projected on to a wall in one of his rooms. He has a relatively large yard area devoid of any equipment.

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43 Queensland Government, *A Guide for Families, Positive Behaviour Support and the use of Restrictive Practices* 8 <http://www.communities.qld.gov.au/disability/key-projects/positive-futures/publications-and-resources> (accessed 13 April 2013).

44 *Disability Services Act 2006* (Qld) s 146.

45 *MJI* [2010] QCAT 76.

> This area is totally enclosed via either a brick wall or fine wire mesh about 4 metres high. It has been described as a caged area.[46]

In Tasmania, detention or containment would be considered a 'personal restriction' which includes the taking of an action that 'restricts the liberty of movement of the person',[47] and so would need to be approved by the Guardianship and Administration Board.[48]

In contrast to Queensland and Tasmania, Victoria and the Northern Territory regulate the civil detention of people with intellectual impairment as supervised treatment (Victoria) or involuntary treatment (Northern Territory) rather than as a restrictive practice. Nevertheless, they are regulated under their respective disability legislation. In Victoria, a person with intellectual disability may be subject to a supervised treatment order that is made by VCAT,[49] upon application by an authorised program officer in a residential service.[50] In the Northern Territory, an adult with a complex cognitive impairment may be admitted for involuntary treatment and care into a secure care facility on the order of the Local Court,[51] or upon application of the chief executive officer of the agency responsible for disability services.[52] These supervised or involuntary treatment orders provide legal authority to keep a person at a secured residential service and to receive involuntary treatment and care.

B Seclusion

Seclusion is the confinement of a person alone in a room or area from which their free exit is prevented. Unlike detention, seclusion is usually time-limited. In Queensland, the definition is 'to physically confine the adult alone at any time of the day or night, in a room or areas from which free exit is prevented'.[53] It is regulated as a restrictive practice in Queensland, Victoria and the Northern Territory. In Tasmania, seclusion would be considered a 'personal restriction'.[54]

In Queensland, the Northern Territory and Victoria, where seclusion is regulated as a restrictive practice, the legislation requires certain conditions to be met, such as access to appropriate bedding and clothing, heating and cooling, food and drink and toilet arrangements, when a person is being secluded.[55]

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46 *MJI* [2010] QCAT 76 at [27]-[28].
47 *Disability Services Act 2011* (Tas) s 34.
48 Ibid s 42.
49 *Disability Act 2006* (Vic) s 193.
50 Ibid s 191.
51 *Disability Services Act* (NT) s 12.
52 Ibid s 8.
53 *Disability Services Act 2006* (Qld) s 144.
54 *Disability Services Act 2011* (Tas) s 34.
55 *Disability Act 2006* (Vic) s 140(d); *Disability Services Act 2006* (Qld) s 165; *Disability Services Act* (NT) s 41(2)(d).

Anecdotally, it seems seclusion is used in order to de-escalate behaviour that is likely to cause harm to the person or others, as is indicated by the following example from a Queensland government publication:

> Kathy receives 24-hour accommodation support. She lives with three other women. When she and her flatmates are leaving for work in the morning she can act up and hurt other people. When this happens, Kathy's support worker locks Kathy in her bedroom until she calms down. This action is a restrictive practice as Kathy is being secluded.[56]

This understanding is also supported by the literature, where seclusion for people with intellectual impairment is described as 'the use of supervised confinement of a patient in a room. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others'.[57]

With the exception of the Northern Territory, the respective legislative frameworks in the disability services legislation do not impose restrictions on the amount of time a person may be subject to seclusion, so theoretically a person could be secluded for an indefinite period of time. In the Northern Territory, a person cannot be secluded for a continuous period longer than three hours.[58]

Nevertheless, in Queensland, time restrictions could be applied as a condition or part of an approval by a decision maker. In *HRJ*,[59] for example, the positive behaviour support plan referred to a maximum of two hours of seclusion per day.[60] In Victoria, seclusion must not be used for longer than the period of time authorised by the Authorised Program Officer or the period of time it is considered necessary (whatever is the shortest);[61] and in Tasmania, restrictive interventions generally must be carried out in accordance with any conditions or limitations imposed by either the Secretary or the Guardianship and Administration Board.[62]

Without time restrictions being legislatively enshrined, however, there is no guarantee that seclusion will be used as a time-limited strategy. In the Queensland case of *HRJ*[63] discussed above, although the positive behaviour support plan limited seclusion for up to two hours per day, HRJ was in fact often secluded up to 16 hours per day.[64] When used in this way, the distinction between seclusion and containment or detention can seem an illusory one. This is particularly significant, as seclusion is generally regulated as a restrictive practice, but detention is usually not.

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[56] Queensland Government, *A Guide for Families, Positive Behaviour Support and the use of Restrictive Practices*, 8 <http://www.communities.qld.gov.au/disability/key-projects/positive-futures/publications-and-resources> (accessed 13 April 2013).
[57] Hazel Powell, Allison Alexander and Thanos Karatzias, 'The use of seclusion in learning disability services' (2008) 11(5) *Learning Disability Practice* 12.
[58] *Disability Services Act* (NT) s 41(2)(d)(vi).
[59] *HRJ* [2011] QCAT 712.
[60] *HRJ* [2011] QCAT 712 at [11].
[61] *Disability Act 2006* (Vic) s 140(c)(iii).
[62] *Disability Services Act 2011* (Tas) s 36(1)(a)(ii).
[63] *HRJ* [2011] QCAT 712.
[64] Ibid [17].

The distinction between the authorisation of the time-limited practice of seclusion, and confining a person to a particular residence (detention) was discussed in the case of *LM*.[65] This case was heard in Victoria, where detention is not regulated as a restrictive practice, but is authorised as part of a supervised treatment order. In this case, evidence was submitted to the Tribunal that it was necessary, not only to subject LM to seclusion from time to time, but also to lock the door of the residential service where LM was living to prevent her from leaving and causing harm to either herself or others. It was submitted to the Tribunal that restrictive practices under Part 7 of the *Disability Act 2006* (Vic) only allowed LM to be secluded, which was described as being 'akin to a timeout'.[66] The power conferred by a supervised treatment order would be more far-reaching. It would allow workers to detain her against her will in the service and return her to the service to be detained if she was in the community, as well as give authority to the police to return her to the service against her will. The Tribunal agreed and also commented that while a guardian could make a decision for LM to reside at the service, the guardian could not make a decision to detain her there for treatment, nor could this be authorised under the restrictive practices regime.[67]

C Physical restraint

Physical restraint involves the application of physical force by a person on another person for the purpose of controlling that person's behaviour. It is distinct from other types of restraints, such as mechanical restraint, in that a device is not used to restrain the person, but rather restraint is applied by any part of the person's body (this being the person who is seeking to restrain another). The degree of force applied is irrelevant. It is defined by the fact that it restricts the other person's freedom of movement.

In Queensland, physical restraint is defined as 'the use, for the primary purpose of controlling the adult's behaviour, of any part of another person's body to restrict the free movement of the adult'.[68] It is regulated as a restrictive practice in Queensland and the Northern Territory. In Tasmania, it is regulated as a 'personal restriction' and the following example is provided:

> A attends a day support centre that includes 20 other participants. A has an intellectual disability. A has a tendency to hit other people in the head when they get too close to her. Staff can see when this is about to happen and they grab hold of her hands and keep holding until the other person moves away. Staff do this to prevent injury to A and to the others around her.[69]

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65 *LM (Guardianship)* [2008] VCAT 2084.
66 Ibid [78].
67 Ibid [92].
68 *Disability Services Act 2006* (Qld) s 144.
69 Department of Health and Human Services Tasmania, *Fact Sheet - Personal Restrictions* <http://www.dhhs.tas.gov.au/disability/publications/easy_english_fact_sheets/tasmanian_disability_services_act_2011_fact_sheets/fact_sheet_-_personal_restrictions> (accessed 20 April 2013).

The blocking of physical blows from a person with a disability has also been considered a physical restraint in Queensland.[70]

In Victoria, it is regulated differently as an 'other restrictive intervention'.[71] The Senior Practitioner (a statutory position under the *Disability Act 2006* (Vic))[72] is empowered to issue guidelines, standards and directions to service providers in relation to the practice,[73] including directions to prohibit physical restraint. In May 2011, the Senior Practitioner issued a direction under section 150 of the *Disability Act 2006* (Vic) that prohibits the use of physical restraint except in accordance with the issued direction.[74] Specific types of physical restraint have been prohibited from use such as prone restraints,[75] supine restraints[76] and pin downs.[77] Physical restraint may only be applied to a person in a number of defined exceptional circumstances such as an in unplanned emergency situation[78] or in accordance with a 'duty of care exception'.[79] The justification for the directive is that physical restraint is a very serious restriction on a person's human rights and is associated with a high risk of injury, including death to those upon whom it is used, as well as a risk of harm to service providers who use it.[80]

Other jurisdictions, including Queensland, Northern Territory and Tasmania do not place any restrictions on the types of physical restraint that can be applied.

D Mechanical restraint

Mechanical restraint is the use of a device, such as a splint or strap, to restrict a person's movement for the purpose of controlling their behaviour. It is regulated as a restrictive practice in Queensland, Victoria and Tasmania, but not in the Northern Territory. In Tasmania, it is regulated as a 'personal restriction' which is defined to

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70 *PMD* [2011] QCAT 353.

71 *Disability Act 2006* (Vic) s 150.

72 The Senior Practitioner is appointed under s 23 of the *Disability Act 2006* (Vic) and fulfils the role of the senior clinician recommended by the Victorian Law Reform Commission: see above n 21 and associated text.

73 *Disability Act 2006* (Vic) s 150.

74 Department of Human Services Victoria, *Senior Practitioner Victoria Physical Restraint Direction Paper* (May 2011).

75 Defined as subduing a person by forcing them into a facedown position: Department of Human Services Victoria, *Senior Practitioner Victoria Physical Restraint Direction Paper* (May 2011) 6.

76 Defined as subduing a person by forcing them into a face-up position: Ibid.

77 Defined as subduing a person by holding down their limbs or any part of the body, such as their arms or legs: Ibid.

78 An unplanned emergency applies to circumstances in which a behaviour displayed by a person is new, unpredicted or not known as part of the person's history or known repertoire of behaviours: Ibid.

79 'Duty of care' is broadly defined as the need to take necessary action where reasonably required in a situation to prevent and or reduce foreseeable harm from occurring to a person or people; the least restrictive principle is applied in these circumstances: Ibid.

80 Ibid 9.

include 'an action that restricts the liberty of movement of a person.'[81] In Queensland, it is defined to mean 'the use, for the primary purpose of controlling the adult's behaviour, of a device … to — (a) restrict the free movement of the adult; or (b) prevent or reduce self-injurious behavior.'[82] A similar definition is used in Victoria,[83] and both Victoria and Queensland exclude devices used for therapeutic purposes or to enable safe transportation, such as seat belts on a wheel chair. [84] In Victoria, the most commonly reported devices used for mechanical restraint included bodysuits, splints, belts and straps.[85]

There can be a fine distinction between devices that are not mechanical restraints because they are used for therapeutic purposes and those that constitute mechanical restraint and are therefore regulated. In the QCAT decision of *PBA*,[86] the use of an arm splint to stop a person mouthing their hand and causing injury to themselves constituted mechanical restraint,[87] whereas in *GLJ* (another QCAT decision) a helmet used to protect a person's head from injury when the person engaged in head banging the walls and floors of their residence, did not.[88] In this case the helmet was considered to prevent injury, not to control the person's self-injurious behaviour.[89]

E Restricting access

Restricting access to objects that may cause harm to a person is regulated as a restrictive practice in Queensland, the Northern Territory and Tasmania. In Queensland, the practice is defined as 'restricting the adult's access at a place where the adult receives disability services, to an object … to prevent the adult using the object to cause harm to the adult or others',[90] and there is a similar definition in the Northern Territory.[91] In Tasmania, it is regulated as an 'environmental restriction' which is defined to include 'the modification of an object, or the environment of the person, so as to enable the behavioural control of the person.'[92] While it is not regulated as a restrictive practice in Victoria, restricting access could be subject to directives or guidelines by the Senior Practitioner as an 'other restrictive intervention' under s 150 of the *Disability Act 2006* (Vic).

'Restricting access' may potentially be a 'catch-all' for a very wide variety of restrictions. An example of 'restricting access' used in the Northern Territory

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81 *Disability Services Act 2011* (Tas) s 34.
82 *Disability Services Act 2006* (Qld) s 147.
83 *Disability Act 2006* (Vic) s 3.
84 *Disability Act 2006* (Vic) s 3; *Disability Services Act 2006* (Qld) s 147. Queensland also excludes devices for postural support; devices to prevent injury from involuntary bodily movement, such as seizures; and bed rails or guards to prevent injury while the adult is asleep.
85 State Government Victoria, *Senior Practitioner Report 2010-11*, 11.
86 *PBA* [2012] QCAT 82.
87 Ibid [5].
88 *GLJ* [2010] QCAT 436.
89 Ibid [7]-[9].
90 *Disability Services Act 2006* (Qld) s 144.
91 *Disability Services Act* (NT) s 35.
92 *Disability Services Act 2011* (Tas) s 34.

legislation is 'locking a drawer in which knives are kept to prevent a resident from using the knives to cause harm',[93] and in Queensland, the following example was provided in a government publication:

> Ivy is a young woman who has an intellectual disability. Ivy has been known to set fires around the house when she finds matches or lighters. To keep Ivy and other people safe in the house, the matches and lighters are kept locked away in the cupboard, which Ivy is unable to access.[94]

In *RMJ,*[95] QCAT approved restricting access to food and water as a restrictive practice. To prevent RMJ from gorging on large amounts of food, the pantry and fridge were locked when RMJ was not supervised by staff. [96]

F Chemical restraint

Chemical restraint is the use of medication to control a person's behaviour and it is regulated in Queensland, Victoria and the Northern Territory, but not Tasmania. The practice is defined in Victoria to mean 'the use, for the primary purpose of the behavioural control of a person with a disability, of a chemical substance to control or subdue the person.'[97] The determinative factor as to whether medication is characterised as chemical restraint is whether its primary purpose is for the behavioural control of a person, rather than for the treatment of a diagnosed mental illness or other physical condition. Medication for the treatment of a mental illness or physical condition is excluded by all jurisdictions from the definition of chemical restraint.[98]

Whether medication is administered for the primary purpose of controlling behaviour can sometimes be difficult to ascertain, and while evidence from a treating medical practitioner or psychiatrist may often be accepted, this is not always the case. In *RMJ,*[99] for example, QCAT found that, contrary to evidence from a psychiatrist, medication including Luvox and Rispiradone were used primarily for behavioural control and thus constituted chemical restraint.[100] RMJ was a man with intellectual disability who had received medication for over 30 years. RMJ's general practitioner asserted that this was to manage his agitated and aggressive behaviour. A more recent report by RMJ's psychiatrist, however, indicated that RMJ had been newly diagnosed with a mental illness and that the same medication, Luvox and Rispiradone, were now used for the purpose of treating a 'mood disorder'. No information was

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93 *Disability Services Act* (NT) s 35.
94 Queensland Government, *A Guide for Families, Positive Behaviour Support and the use of Restrictive Practices* (2013) 10 <http://www.communities.qld.gov.au/disability/key-projects/positive-futures/publications-and-resources> (accessed 13 April 2013).
95 *RMJ* [2011] QCAT 700.
96 Ibid [9].
97 *Disability Act 2006* (Vic) s 3.
98 *Disability Services Act 2006* (Qld) s 145; *Disability Act 2006* (Vic) s 3; *Disability Services Act* (NT) s 34.
99 *RMJ* [2011] QCAT 700.
100 Ibid [13].

provided to indicate how the diagnosis was made. Nor was there any evidence to indicate a history of mental illness requiring treatment or current information about presenting symptoms. In the absence of this information, the Tribunal did not accept the evidence that RMJ was being administered the medication for the purpose of treating a mental illness and found the use of the medication constituted chemical restraint.

In Victoria, the most common types of medication administered as chemical restraint reported to the Senior Practitioner's office include: atypical antipsychotics (60 per cent); antidepressants (34 per cent); mood stabilisers (34 per cent); typical antipsychotics (20 per cent); and benzodiazepines (17 per cent).[101] Polypharmacy, the use of multiple medications, is also very common, with 60% of people with disability administered more than one type of chemical restraint.[102]

V CRITERIA FOR THE LAWFUL USE OF RESTRICTIVE PRACTICES

All jurisdictions that regulate restrictive practices require certain criteria to be met before restrictive practices can be approved or used. The most common include that the restrictive intervention is necessary to *prevent harm* to the person or others, that the restrictive practice is the *least restrictive* in the circumstances, and that a behaviour support plan is prepared. Table 4 sets out the criteria that must be applied in the various jurisdictions before restrictive practices can be used.

The relevant decision-makers in each jurisdiction assess whether the criteria have been met prior to approving restrictive practices. As mentioned earlier, the decision-maker in Queensland is either QCAT or a guardian for restrictive practice matters; in Tasmania, the secretary or the Guardianship and Administration Board; and in Victoria, the secretary and the authorised program officer. In the Northern Territory, if the Chief Executive Officer proposes to apply restrictive practices to a person, certain requirements must be met, for the application of restrictive practices to be lawful under the Disability Act.

Table 4: Criteria for the use of restrictive practices

Criteria	VIC	QLD	TAS	NT
Lack of capacity	Not required	Impaired capacity for restrictive practices[103]	Not required	Not required

[101] Victorian Government, *Senior Practitioner Report 2009-10*, 22.
[102] Ibid.
[103] *Guardianship and Administration Act 2000* (Qld) ss 80V(2)(a), 80ZD(1)(a).

Criteria	VIC	QLD	TAS	NT
Intellectual disability or cognitive impairment	Person with a disability[104]	Adult with an intellectual disability or cognitive impairment[105]	Person with a disability[106]	Person with a disability[107]
Necessary to prevent harm	Use of restraint or seclusion is necessary to: (i) prevent the person from causing physical harm to themselves or any other person; or (ii) prevent the person from destroying property where to do so could involve the risk of harm to themselves or any other person[108]	Adult's behaviour has previously resulted in harm to self or others. There is a reasonable likelihood that the adult's behaviour will cause harm to the adult or others[109]	Not required	Use of restrictive practices is necessary to prevent the resident from causing physical harm to himself or herself or others. Use of restrictive practices is necessary to prevent the resident from destroying property if to do so could involve the risk of harm to himself or herself or others[110]
Least restrictive	The use of the form of restraint or seclusion is the option that is the least restrictive of the person as is possible in the circumstances[111]	It is the least restrictive way of ensuring the safety of the adult or others[112]	The restrictive intervention is the least restrictive of the person's freedom of decision and action as is practicable in the circumstances[113]	The use and form of the restrictive practice is the least restrictive of the resident as is possible in the circumstances[114]

[104] *Disability Act 2006* (Vic) s 133.
[105] *Disability Services Act 2006* (Qld) s 140.
[106] *Disability Services Act 2011* (Tas) ss 38(1), 42(i).
[107] Under the *Disability Services Act* (NT), a restrictive intervention may be used in relation to a resident of a residential facility if certain requirements are met (s 41). A resident of a residential facility includes a person with a disability (s 2).
[108] *Disability Act 2006* (Vic) s 140(a).
[109] *Guardianship and Administration Act 2000* (Qld) ss 80V, 80ZE(4).
[110] *Disability Services Act* (NT) s 41(2)(a).
[111] *Disability Act 2006* (Vic) s 140(b).
[112] *Guardianship and Administration Act 2000* (Qld) ss 80V, 80ZE(4)(c).

Criteria	VIC	QLD	TAS	NT
Behaviour support plan	The use of restraint or seclusion is included in the person's behaviour support plan[115]	A positive behaviour support plan has been developed for the adult[116]	Not required	The use and form of restrictive intervention is in accordance with the resident's behaviour support plan[117]
Benefit	The behaviour support plan must explain how the use of restraint or seclusion will be of benefit to the person[118]	If the plan for the adult is implemented- the risk of the adult's behaviour causing harm will be reduced or eliminated; and the adult's quality of life will be improved in the long term[119]	The restrictive intervention will be carried out for the primary purpose of ensuring the safety, health or wellbeing of the person or other persons[120]	The behaviour support plan must include proactive strategies to build on the person's strengths and increase the person's life skills[121]
Clinical assessment	Not required	The adult has been adequately assessed by appropriately qualified persons, within the meaning of the DSA, section 123E, in the development of	Not required	Not required

[113] *Disability Services Act 2011* (Tas) ss 38(4)(b), 43(1)(b).
[114] *Disability Services Act* (NT) s 42(2)(b).
[115] *Disability Act 2006* (Vic) s 140(c).
[116] *Guardianship and Administration Act 2000* (Qld) ss 80V, 80ZE(2).
[117] *Disability Services Act* (NT) s 41.
[118] *Disability Act 2006* (Vic) s 141(2)(b).
[119] *Guardianship and Administration Act 2000* (Qld) ss 80V(2)(f), 80ZE(4)(g).
[120] *Disability Services Act 2011* (Tas) s 43(1)(a).
[121] *Disability Services Act* (NT) s 36(2).

Criteria	VIC	QLD	TAS	NT
		the positive behaviour support plan for the adult[122]		

A Disability, capacity and age

In Queensland, for a person to be subject to the restrictive practices regime, the person must be an adult, have an intellectual or cognitive disability, and lack capacity to make a decision about restrictive practice matters.[123]

In Victoria, Tasmania and the Northern Territory, the legislative frameworks apply broadly to people with a disability. There is no requirement for a person to have an intellectual disability, cognitive impairment or to lack decision-making capacity for restrictive practices,[124] and nor must the person be an adult.

While the legislation in these jurisdictions apply more broadly to people with disability,[125] in practice they tend only to be applied to people with intellectual disability or cognitive impairment. For example, in Victoria it has been reported that the majority of people subject to restrictive practices do have an intellectual disability or acquired brain injury.[126] Nevertheless, the potential breadth of the criteria is concerning, given that a broad range of people could be classified as having a disability, and thus potentially subject to practices such as restraint and seclusion, even if they do not have a disability that affects their intellectual or cognitive capacity.

Queensland is also the only jurisdiction that limits the application of restrictive practices legislation to adults. So in Victoria, it is reported, that of all children with a disability receiving a funded service (approximately 6,700 in 2011-12),

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[122] *Guardianship and Administration Act 2000* (Qld) ss 80V(2)(e), 80ZE.

[123] *Disability Services Act 2006* (Qld) s 139.

[124] Both Victoria and the Northern Territory do require that a person has an intellectual disability for the purposes of authorising involuntary treatment: *Disability Act 2006* (Vic) s 191(1)(a); *Disability Services Act* (NT) s 5.

[125] Disability is defined similarly in each jurisdiction. In Victoria, for example, 'disability' is defined to be inclusive of intellectual disability and a developmental delay, but also includes 'a sensory, physical or neurological impairment or acquired brain injury or any combination thereof, which is, or is likely to be permanent, causes a substantially reduced capacity in at least one of the areas of self-care, self-management, mobility or communication; and requires ongoing or significant long term or episodic support': *Disability Act 2006* (Vic) s 3.

[126] Lynne Webber, Keith McVilly, Elaine Stevenson and Jeffrey Chan, 'The use of restrictive interventions in Victoria, Australia: Population data for 2007-2008' (2010) 35 *Journal of Intellectual and Developmental Disability* 199, 200.

approximately five percent (337 children) were subject to chemical restraint on a routine basis and less than one percent were subject to mechanical restraint (32 children) or seclusion (2 children).[127]

B Preventing harm

Like many involuntary treatment regimes, the harm criterion is also central to all restrictive practices regimes. The adult must have demonstrated behaviour that is, has or is likely to cause harm to the adult or others. Such behaviour is sometimes colloquially referred to as 'challenging behaviour',[128] though this is not a term used in the legislation. A common definition of such behaviours from Emerson was noted earlier: 'culturally abnormal behaviour(s) of such intensity, frequency and duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit the use of or result in the person being denied access to ordinary community facilities'.[129]

Some commentators have expressed concerns about this terminology, stating that the language used to describe people with intellectual disability has played a significant role in 'highlighting their disabling conditions rather than their experiences in full, and in doing so have inadvertently perpetuated stereotypes about, and prejudice, toward them'.[130] The term 'behaviours of concern' is preferred by some, which it is argued carries less of a social stigma and also points to the appropriate response by professionals. It has been pointed out that 'behaviours that challenge' can be viewed as legitimate responses to maladaptive environments; rather than simply origins in the people who exhibit them.[131] This critique reflects a growing body of work that highlights that restrictive practices are often used in lieu of appropriate supports and the importance of working to understand the causes and triggers of such behaviours so that the response can be a preventative one, with a focus on changing services, systems and environments.[132]

In most cases, it is only necessary to show the potential for harm to the adult or others in the future. Sometimes the 'harm' is qualified by the fact that it must be 'physical' harm.[133] Queensland is the only jurisdiction to require both evidence of harm to the

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[127] Victorian Government, *Senior Practitioner Report 2011-2012*, 15.
[128] William Carter QC, above n 4.
[129] Emerson, above n 2.
[130] Jeffrey Chan, 'Is it time to drop the term "challenging behavior"?' (2012) 15 *Learning Disability Practice* 36; Disability Rights Now, above n 1, 91–101.
[131] Ibid; Disability Rights Now, above n 1, 91–101.
[132] Chan, above n 130; Disability Rights Now, above n 1, 91–101; Jeanne Hayes and Elizabeth Hannold, 'The Road to Empowerment: A Historical Perspective on the Medicalisation of Disability' (2007) 30(3) *Journal of Health and Human Services Administration* 352; Royal College of Psychiatrists, 'Challenging Behaviour: A Unified Approach' (College Report CR144, British Psychological Society and Royal College of Speech and Language Therapists, 2007) <http://www.rcpsych.ac.uk/files/pdfversion/cr144.pdf>.
[133] *Disability Act 2006* (Vic) s 140(a)(i); *Disability Services Act* (NT) s 41(2)(a)(i).

adult or others in the past as well as a reasonable likelihood that harm will occur in the future.[134]

Tasmania requires that the relevant decision-maker consider factors such as 'the consequences to the person with disability, or other persons, if restrictive intervention of that type is not carried out',[135] and 'whether, and the extent to which, carrying out the restrictive intervention will promote or reduce the safety, health and wellbeing of the person with disability.'[136]

A wide range of behaviours have been held by QCAT to constitute 'harm'. For example, in *SAP*[137] the relevant behaviours included moving during haircuts, necessitating physical restraint, and hand mouthing; necessitating mechanical restraint.[138] In *MJI*,[139] a case involving approval of containment and seclusion, the behaviours included 'fire lighting, physical aggression, attempting to grab a steering wheel with intention to crash the car, property damage, use of property as a weapon and throwing objects'.[140]

C Least restrictive option

All jurisdictions require that the restrictive practices used are the least restrictive necessary in the circumstances.[141] This could be demonstrated by describing the range of strategies that have been attempted in the past but have not successfully stopped the behaviours that cause harm, or potential harm. For example, in *WRM*,[142] the adult had a history of self-injurious behaviours including hitting herself on the forehead hard with a closed fist and sucking and biting her wrist causing the skin to break and bleed. The Tribunal heard evidence that other strategies had been used by her family and carers including diversion, trying to physically stop her or giving her a task or ignoring the behaviours, talking with her, offering a tissue and taking her for a short walk.[143] The Tribunal approved mechanical restraint to stop WRM from causing harm to herself, because 'although other positive and preventative techniques are used by the service provider, these techniques are not always successful'.[144]

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[134] *Guardianship and Administration Act 2000* (Qld) s 80V(2)(b). This is the criteria for QCAT to approve containment and seclusion.
[135] *Disability Services Act 2011* (Tas) s 38(5)(c).
[136] Ibid s38(5)(f).
[137] *SAP* [2010] QCAT 282.
[138] Ibid.
[139] *MJI* [2010] QCAT 76.
[140] Ibid [44].
[141] *Disability Act 2006* (Vic) s 140(b); *Disability Services Act* (NT) s 41(2)(b); *Guardianship and Administration Act 2000* (Qld) s 80V(2)(d); *Disability Services Act 2011* (Tas) ss 38(4)(b), 43(1)(b).
[142] *WRM* [2011] QCAT 109.
[143] Ibid [18].
[144] Ibid [32].

D A behavior support plan and benefit

The requirement for restrictive practices to be implemented in accordance with a behaviour support plan is a defining feature of all the restrictive practices regimes, with the exception of Tasmania.[145]

A behaviour support plan, or positive behaviour support plan as it is referred to in Queensland, is derived from an evidenced-based approach to reducing behaviours of harm in people with intellectual disability known as positive behaviour support. This approach developed in the late 1980s, and derived from the principles of both applied behaviour analysis and the normalisation/inclusion movement.[146] It aims to work both with an individual to minimise their 'challenging behaviours' and with systems to change an individual's living environment with the overall aim of improving the person's quality of life.[147] The behaviour support plan is informed by a functional assessment of the person's behaviour that enables identification of triggers for the difficult behaviour and factors that might maintain it. The overall aim is to 'render the problem behaviour irrelevant, inefficient and ineffective by helping the individual achieve his or her goals in a socially acceptable manner, thus reducing, or eliminating altogether, episodes of problem behavior'.[148]

The legislative requirements for a behaviour support plan vary, but generally include: a description of the behaviour that causes harm;[149] the restrictive practices to be used;[150] and a demonstration that the restrictive practices are the least restrictive practices necessary to manage the person's behaviour.[151] Queensland has the most extensive requirements for what is called a 'positive behaviour support plan'.[152]

Some kind of benefit to the person subject to restrictive practices must also be demonstrated in most jurisdictions. While the actual term 'benefit' is not usually used, the concept of benefit is most often associated with the preparation of a behaviour support plan. In Victoria, for example, it is a requirement that the behaviour support plan explain how the use of restraint or seclusion will be of benefit to the person,[153] and Queensland requires that if the plan is implemented not only will the risk of the adult's behaviour causing harm be reduced or eliminated, but that

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[145] *Disability Act 2006* (Vic) s 141; *Disability Services Act 2006* (Qld) s 150; *Disability Services Act* (NT) s 37.
[146] Edward Carr et al, 'Positive Behavior Support: Evolution of an applied science' (2002) 4(1) *Journal of Positive Behaviour Support Interventions* 4, 4-5.
[147] Ibid.
[148] Ibid.
[149] *Disability Services Act 2006* (Qld) s 150(2)(a); *Disability Act 2006* (Vic) s 141(2)(a); *Disability Services Act* (NT) s 37(2).
[150] *Disability Services Act 2006* (Qld) s 150(2)(c); *Disability Act 2006* (Vic) s 141(2); *Disability Services Act* (NT) s 37(2).
[151] *Disability Services Act 2006* (Qld) s 150(2)(b); *Disability Act 2006* (Vic) s 141(2)(c); *Disability Services Act* (NT) s 37(2)(c).
[152] *Disability Services Act 2006* (Qld) s 150.
[153] *Disability Act 2006* (Vic) s 141(2)(b).

the adult's quality of life will be improved in the long term.[154] Similarly, in the Northern Territory, the behaviour support plan must include proactive strategies to build on the person's strengths and increase the person's life skills.[155]

Tasmania does not require the preparation of a behaviour support plan, but the primary purpose of carrying out the restrictive intervention must be for ensuring the safety, health or wellbeing of the person or other persons.[156]

E Clinical Assessment

Only Queensland's legislation requires a clinical assessment of a person before they are subject to restrictive practices.[157] An assessment must be carried out by an 'appropriately qualified person'.[158] Depending on the circumstances of the case, such a person might be a behaviour analyst, medical practitioner, psychologist, psychiatrist, or speech and language pathologists. The nature of the assessment required in Queensland's legislation is closely aligned with the functional analysis needed to inform the development of the positive behaviour support plan.[159] The legislation outlines, for example, that the purpose of the assessment is to make findings about the nature, intensity, frequency and duration of the behaviour of the adult that causes harm to the adult or others and to develop theories about the factors that contribute to the adult's behaviour, as well as strategies for reducing the intensity, frequency and duration of the behaviour.

VI SAFEGUARDS

Effective safeguards are a critical part of restrictive practices legislation given the significant infringement on a person's liberty, the impact on their human rights and the vulnerability of the cohort to whom restrictive practices are applied. Safeguards can include placing time limits on approvals to use restrictive practices as well as opportunities to regularly review and then monitor their use. Without time limited approvals and regular reviews there is a danger of restrictive practices being applied indefinitely. While the approach varies, each jurisdiction provides some important safeguards for the use of restrictive practices, the nature of which depend on whether an administrative or guardianship model is utilised.

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[154] *Guardianship and Administration Act 2000* (Qld) s 80V(2)(f).
[155] *Disability Services Act* (NT) s 36(2).
[156] *Disability Services Act 2011*(Tas) ss 38(5)(f), 43(1)(a).
[157] Although assessments are not required for short term approvals or the use of restrictive practices in community access or respite services.
[158] Such a person is defined to mean 'a person with the qualifications or experience appropriate to conduct the assessment': *Disability Services Act 2006* (Qld) s 159.
[159] *Disability Services Act 2006* (Qld) s 158(3).

A Time limited approvals

Only Queensland and Tasmania's legislation imposes time limits during which a restrictive practice can be used. In Queensland, an approval for containment and seclusion by QCAT is limited to a maximum of 12 months.[160] An appointment of a guardian for restrictive practices is limited to two years.[161] In Tasmania, the Secretary's approval of environmental restrictions and the Guardianship and Administration Board's approval of personal restrictions are limited to a maximum of 90 days,[162] (or 6 months if a hearing has taken place in the case of the Guardianship and Administration Board).[163] While time limits are not imposed in Victoria, time limitation could be a condition placed on the authorised program officer's approval.[164]

B Review of the decision to use restrictive practices

In Queensland, a guardian's decision to consent to restrictive practices is not subject to administrative review; that is, a review of the 'correctness' of the decision to approve restrictive practices. There is greater access to administrative review in the other jurisdictions that predominately utilise administrative decision-making models, such as Victoria and Tasmania.[165]

While these rights to administrative review are provided, their exercise is dependent upon the person with disability (or their representative) seeking a review. This may be problematic for people who are highly vulnerable, may have difficulty communicating without support and assistance and are often quite isolated. For this reason, there seems to be very few applications for administrative review, particularly initiated by those subject to restrictive practices.

C Review of the person's ongoing need for restrictive practices

A review of the 'correctness' of the original decision, that is an administrative review, can be distinguished from other types of reviews where the objective is to review the person's condition and ongoing need for restrictive practices.

In most cases it is the review of the person's behaviour support plan that provides the key opportunity for this type of review. The service provider who seeks to use the

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[160] *Guardianship and Administration Act 2000* (Qld) s 80Y(2).
[161] Ibid s 80ZD(4).
[162] *Disability Services Act 2011* (Tas) ss 39(3), 44(3).
[163] Ibid s 44(3).
[164] *Disability Act 2006* (Vic) s 145.
[165] A person subject to restrictive practices can apply for a review of the decision to use restrictive practices in Victoria, the Northern Territory and Tasmania. In Tasmania a person subject to restrictive practices can apply for an administrative review of the original decision by the secretary to approve the use of environmental restrictions to the Administrative Appeals Division of the Magistrates Court (*Disability Services Act 2011* (Tas), s 48). Victoria and the Northern Territory allow a person subject to restrictive practices to apply for a review of the decision to include restrictive practices in the person's behaviour support plan. In Victoria, the review is to VCAT and in the Northern Territory it is to a statutory review panel.

restrictive practice is responsible for the review of the behaviour support plan. In Queensland, Victoria and the Northern Territory, the jurisdictions that require the development of a plan equivalent to the positive behaviour support plan, the plan must be reviewed at least every 12 months.[166]

Most jurisdictions also allow the person subject to restrictive practices to initiate a review, or the decision maker may review the use of restrictive practices of its own volition at any time. For example, QCAT or other specified persons[167] may review the approval of containment or seclusion[168] or the appointment of a restrictive practice guardian[169] at any time. In Tasmania, the Secretary or Guardianship and Administration Board may at any time, or on the application of specified persons, review the approval of restrictive interventions.[170] In the Northern Territory, a resident of a residential facility subject to restrictive practices may apply to the review panel for a review of the inclusion of restrictive practices in the behaviour support plan.[171]

D Monitoring and oversight

Monitoring and oversight of the use of restrictive practices is an important safeguard in a regulatory regime. In its absence, there is a risk that service providers can continue to use practices such as restraint and seclusion with impunity or for reasons of convenience. It is also necessary to monitor the quality and efficacy of behaviour support plans for people who are subject to restrictive practices to ensure they are achieving their purpose of reducing and eliminating the need to use restrictive practices. The existence of comprehensive and reliable data on the use of restrictive practices is crucial for the systemic monitoring and oversight of these practices.

The regulatory regimes in Victoria and Tasmania include a specific statutory officer, known as the Senior Practitioner, who gathers data and reports on the use of restrictive practices. The role also includes an educative advice and general monitoring function. In Victoria, the senior practitioner is also empowered to give directions in relation to the use of restrictive practices, including the power to direct a service provider to discontinue the use of restrictive practices.[172] Neither Queensland nor the Northern Territory have equivalent statutory positions, although as in other states, the relevant Adult Guardian, Public Advocate and Public Guardian have functions that include a protective and advocacy role that would encompass those people with disability who are subject to restrictive practices. Community Visitors in

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[166] *Disability Act 2006* (Vic) s 142(1)(a); *Disability Services Act* (NT) s 39(1); *Disability Services Act 2006* (Qld) s 150(3).

[167] Specified people include the adult, an interested person for the adult, a relevant service provider to whom the approval relates, the Chief Executive, the Adult Guardian, the Director of Mental Health (if the person is subject to a forensic order) or the Director of Forensic Disability (if the person is subject to a forensic order disability): *Guardianship and Administration Act 2000* (Qld) s 80ZA.

[168] *Guardianship and Administration Act 2000* (Qld) s80ZA.

[169] Ibid s 29.

[170] *Disability Services Act 2011* (Tas) ss 40(1), 45(2).

[171] *Disability Services Act* (NT) s 40.

[172] *Disability Act 2006* (Vic) s 27.

each jurisdiction, with the exception of Tasmania, are also empowered to visit places where restrictive practices are used.[173] In Queensland, service providers who use restrictive practices are required to give information to the chief executive in a manner prescribed in a regulation.[174]

VII CONCLUDING THOUGHTS: CONSIDERATIONS FOR GOVERNMENTS

What emerges from the foregoing discussion is that restrictive practices for people with intellectual disability or cognitive impairment are governed by a hotchpotch of regulation (or not) across Australia. While four jurisdictions (Victoria, Queensland, Tasmania and the Northern Territory) have legislation dealing specifically with restrictive practices, the remaining four jurisdictions do not. And even within those four legislative jurisdictions, the regulation of restrictive practices is limited to those disability services either provided or funded by the state government.

There is likely to be further legislative change in this area in the foreseeable future. Four jurisdictions are yet to have legislation, and there is also the prospect of further reform in the jurisdictions that have already chosen to legislate in preparation for the NDIS. As noted in the introduction, impetus for reform is likely to come from the NDIS, the proposed *National Framework for Reducing the Use of Restrictive Practices*,[175] the Australian Law Reform Commission's inquiry into equal recognition before the law and legal capacity for people with disability,[176] and the *Convention on the Rights of Persons with Disabilities*.[177] Although the Australian Law Reform Commission has called for a nationally-consistent response to restrictive practices, it has not made any recommendations about the form any national approach should take, except to state that broadly it is likely such an approach would incorporate legislation, national guidelines, codes of practice and policy directives, as well as education, training and guidance.[178]

We support the calls for restrictive practices legislation in those jurisdictions where this sort of conduct is currently unregulated. These regulatory regimes perform a

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[173] *Guardianship and Administration Act 2000* (Qld) s 224; *Disability Act 2006* (Vic) s 30(f); *Disability Services Act* (NT) s 55.

[174] *Disability Services Act 2006* (Qld) s 199. To date these prescribed requirements have not been included in the *Disability Services Regulation 2006* (Qld).

[175] Department of Families, Housing, Community Services and Indigenous Affairs, *Draft Proposed National Framework for Reducing the Use of Restrictive Practices in the Disability Service Sector*, <www.fahcsia.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/draft-proposed-national-framework-for-reducing-the-use-of-restrictive-practices-in-the-disability-service-sector> (accessed 19 November 2013).

[176] Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws: Issues* Paper, Issues Paper No 44 (2013) 82; Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Discussion Paper No 81 (2014) ch 8.

[177] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007 [2008] ATS 12 (entered into force 3 May 2008).

[178] Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Discussion Paper No 81 (2014) 200-201.

number of important functions – and there is no evidence to suggest that these functions are only necessary in the half of Australian jurisdictions that have chosen to legislate. Firstly, restrictive practices regimes regulate standards of care and support provided in disability services and so can be effective in requiring at least certain minimum standards for managing behaviours of concern. Second, they ensure that restrictive practices are not used with impunity or without approval, review, oversight and monitoring. Good decision-making is promoted by sound processes, justifiable criteria and transparency. Third, these regulatory regimes provide certainty and clarity for health professionals and staff, protecting them from exposure to civil and criminal liability where their conduct is appropriate and in accordance with the relevant regulatory requirements. Finally, they also ensure that restrictive practices are not used as an end in themselves, without implementation of a behavioural support approach designed to eliminate, or at least reduce, the need for restrictive practices and improve the person's quality of life.

So what lessons can be learnt from the legislative effort to date by the governments who are grappling with this issue either as first-time actors or as reformers of existing legislation?

The first is that a nationally-consistent approach is desirable as Australia heads towards the NDIS. This desire for a uniform approach is reflected in the *National Framework* which lists as one of the key guiding principles 'A National Approach',[179] although that document itself provides limited guidance as to how this would be achieved. Governments in all jurisdictions, but perhaps particularly those without a current legislative regime, should be mindful of the national perspective when making choices about regulatory approaches. Having regard to data as to how various regimes are actually operating in practice (discussed below) is an important part of those deliberations.

A second lesson for governments is that they should avoid not only inconsistency across the country, but also internally within their own jurisdiction in terms of who is covered by the regime. All four jurisdictions treat those who receive state government provided or funded disability services differently (regulated) from those who do not receive such services (unregulated). There is no justifiable reason for this distinction. The reasons outlined above for why these laws are needed also apply to those cohorts who fall outside the current regime in the four legislative jurisdictions. It is unacceptable that the same safeguards or benefits are not provided to people with intellectual disability and cognitive impairment residing in places other than those where disability services are state government provided or funded. This view was expressed by the Queensland Law Reform Commission in its review of Queensland's guardianship legislation:

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[179] Department of Families, Housing, Community Services and Indigenous Affairs, *Draft Proposed National Framework for Reducing the Use of Restrictive Practices in the Disability Service Sector*, <www.fahcsia.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/draft-proposed-national-framework-for-reducing-the-use-of-restrictive-practices-in-the-disability-service-sector> (accessed 19 November 2013) 4.

> there can be no justification, in principle, of the current two-tiered system in relation to the use of restrictive practices, under which different groups of adults have the benefit (or disadvantage, as the case may be) of differential levels of protection. Moreover, the two-tiered system that currently applies is arguably inconsistent with the United Nations *Convention on the Rights of Persons with Disabilities*.[180]

A recent article by Williams, Chesterman and Laufer discusses the 'legislative gap' in Victoria in relation to people with impaired capacity who face restrictions on their liberty outside of state-funded disability services in aged care services and supported residential services, for example.[181] They consider that, while the restrictive practices regime under the *Disability Act 2006* (Vic) is not ideal, it represents a potential starting point for how restrictive practices should be regulated in these other environments.[182] This issue of a two-tiered system in relation to restrictive practices will become even more significant as state governments divest themselves of responsibility for funding and/or providing disability services as part of the NDIS.

A third lesson for governments relates to the need to look very closely at the current various models that are operating. For example, should an administrative model, a guardianship model, or a hybrid model be preferred? It could be argued, for example, that under an administrative model, the decision-maker who approves the use of restrictive practices (the secretary of the department, an authorised program officer, or a member of a panel established by the service provider) is not sufficiently independent, given that the same decision maker must also consider issues of funding, human resources and service sustainability.

However, it could also be questioned whether guardians are always best placed to make, what are essentially clinical, decisions about whether a person's behaviour indicates the need for detention and restraint, or whether it is evidence of other problems such as a deficiency in the way support is being provided, or an underlying medical or psychological problem. Guardians, who are most often close family members or friends, could also be prone to pressure from service providers to agree to practices for fear of the service relinquishing the care of their family member. On the other hand, guardians and other substitute decision-makers do make many other decisions that have serious consequences for those subject to guardianship, such as whether to consent to withholding or withdrawal of life-sustaining treatment. And arguably, guardians also may bring a degree of independent oversight to the use of restrictive practices in health and disability services.

Williams, Chesterman and Laufer, in their article discussed above, question whether guardianship is the appropriate mechanism for the approval of deprivations of liberty. The authors point out that while guardians may make a range of decisions that result in the restriction of a person's liberty in some sense, such as the decision to admit the

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[180] Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Report No 67 (2010) [19.136] <http://www.qlrc.qld.gov.au/reports/r67_vol_3.pdf>.

[181] Michael Williams, John Chesterman and Richard Laufer, 'Consent versus scrutiny: Restricting liberties in post-Bournewood Victoria' (2014) 21 *Journal of Law and Medicine* 641.

[182] Ibid 658-660.

person to residential care, they argue that the decision to impose continual restrictions on a person's liberty once in care, are of a different nature. These types of restrictions require continual oversight and monitoring, not a one-off consent.[183]

Challenges may also be faced reconciling the current emphasis on enhancing opportunities for supported decision-making within Australia's guardianship system with making decisions about restrictive practices. Consistent with Article 12 of the *Convention on the Rights of Persons with Disabilities*,[184] there is currently an emphasis on reducing the need for substitute decision-making for people with impaired capacity and instead providing the necessary support for a person to exercise their own decisions.[185] It may seem perverse, though, for a person to be supported to make a decision to be physically restrained or confined to their room. However, the ALRC has indicated that any national approach to regulating restrictive practices should incorporate their proposed National Decision Making Principles and encourage the use of supported decision-making.[186]

Regardless of the decision-maker, it is imperative that there is independent oversight by a court or tribunal of decisions to approve restrictive practices as well as a robust system for monitoring and review. With this in mind, and taking into account the issues with guardianship just raised above, reliance on current guardianship regimes does not seem ideal.

Another important decision when designing a restrictive practices framework is whether to consider civil, or preventative, detention as a separate regime. Given the seriousness of depriving a person of their liberty, other than in connection with the alleged commission of a crime, there is a strong argument for the importance of independent assessment by professionals, strict criteria that is assessed by an independent court or tribunal, and regular independent review and monitoring.

A final comment is that part of looking closely at how the existing legislative regimes are working includes consideration of available empirical evidence as to how current systems are working or not. While there are ideological issues at stake in these debates, a good restrictive practices regime needs to function effectively to reduce 'challenging behaviours' and ultimately to eliminate the need to use restrictive practices. Evidence is crucial to adequately assess the efficacy of restrictive practices regulation regimes. The collection of data on the use of restrictive practices in some

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[183] Michael Williams, John Chesterman and Richard Laufer, 'Consent versus scrutiny: Restricting liberties in post-Bournewood Victoria' (2014) 21 *Journal of Law and Medicine* 641, 655.

[184] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007 [2008] ATS 12 (entered into force 3 May 2008).

[185] United Nations, *Handbook for Parliamentarians – From Exclusion to Equality: Realising the Rights of Persons with Disabilities*, United Nations Department of Economic and Social Affairs, Office of the United Nations High Commissioner for Human Rights and Inter-Parliamentary Union, (2007); Nina Kohn, Jeremy Blumenthal and Amy Campbell, 'Supported Decision-Making: A Viable Alternative to Guardianship?' (2013) 117 *Penn State Law Review* 1111, 1112.

[186] Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Discussion Paper No 81 (2014) 202-3.

jurisdictions that regulate restrictive practices such as Victoria was mentioned above when discussing safeguards. The Victorian Senior Practitioner, for example, has found that the quality of positive behaviour support plans was linked to the use of restrictive practices, with plans that reached a certain level of quality associated with a decrease in use of restrictive practices.[187] This available data should not only be carefully examined by the governments who collect this data, to determine the efficacy of their existing regimes, but also by other jurisdictions to inform their deliberations as well.

Restrictive practices such as detention, seclusion and physical, chemical and mechanical restraint represent serious infringements on a person's human rights. When applied to people with intellectual disability or cognitive impairment, many of whom may have difficulty communicating without assistance or support, the impetus for protective safeguards including independent oversight, takes on a greater significance. To achieve the degree of monitoring, oversight and safeguards needed when such severe restrictions are placed on vulnerable people's rights, legislation is needed. Ideally this legislation should provide a consistent approach to all people with intellectual disability and cognitive impairment subject to such restrictions on their liberties within a jurisdiction, regardless of where they are living. Ideally a nationally-consistent approach should also be developed. As developments at a state, national and international level push towards greater regulation of this challenging issue, it is crucial that a deliberate, evidence-based approach to reform is utilised and that governments collect data that provides transparency and the ability to measure the efficacy of these restrictive practices regulatory regimes to achieve their ultimate objectives: to reduce and eliminate the need to use restrictive practices.

[187] State Government Victoria, *Senior Practitioner Report 2012-13* (Department of Human Services) 21. Lynne Webber, Ben Richardson, Frank Lambrick and Tarryn Fester, 'The Impact of the Quality of Behaviour Support Plans on the Use of Restraints and Seclusion in Disability Services' (2012) 2(2) *International Journal of Positive Behavioural Support* 3.