



Women
With
Disabilities
Australia
(WWDA)



ROYAL COMMISSION INTO VIOLENCE, ABUSE, NEGLECT AND EXPLOITATION OF PEOPLE WITH DISABILITY

WWDA RESPONSE TO THE 'RESTRICTIVE PRACTICES' ISSUES PAPER

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Women With Disabilities Australia (WWDA) has Special Consultative Status with the Economic and Social Council of the United Nations.

Awards

Winner

National Human Rights Award 2001

Winner

National Violence Prevention Award 1999

Winner

Tasmanian Women's Safety Award 2008

Nominee

UNESCO Prize for Digital Empowerment of Persons with Disabilities 2021

Nominee

French Republic's Human Rights Prize 2003

Nominee

UN Millennium Peace Prize for Women 2000

Certificate of Merit

Australian Crime & Violence Prevention Awards 2008

Nominee

National Disability Awards 2017

ABOUT WOMEN WITH DISABILITIES AUSTRALIA (WWDA)

[Women With Disabilities Australia \(WWDA\)](#) is the national Disabled People's Organisations (DPOs) for women, girls, feminine identifying and non-binary people with disability in Australia. As a DPO, WWDA is run by and for women, girls, feminine identifying and non-binary people with disability.

WWDA uses the term 'women and girls with disability', on the understanding that this term is inclusive and supportive of, women and girls with disability along with feminine identifying and non-binary people with disability in Australia.

WWDA represents more than 2 million women and girls with disability in Australia, has affiliate organisations and networks of women with disability in most States and Territories, and is recognised nationally and internationally for our leadership in advancing the rights and freedoms of all women and girls with disability. Our organisation operates as a transnational human rights organisation - meaning that our work, and the impact of our work, extends much further than Australia. WWDA's work is grounded in a human-rights based framework which links gender and disability issues to a full range of civil, political, economic, social and cultural rights.

Disabled People's Organisations (DPOs) are recognised around the world, and in international human rights law, as self-determining organisations led by, controlled by, and constituted of, people with disability. DPOs are organisations of people with disability, as opposed to organisations which may represent people with disability. The United Nations Committee on the Rights of Persons with Disabilities has clarified that States should give priority to the views of DPOs when addressing issues related to people with disability. The Committee has further clarified that States should prioritise resources to organisations of people with disability that focus primarily on advocacy for disability rights and, adopt an enabling policy framework favourable to their establishment and sustained operation.¹

ABOUT THE UNIVERSITY OF TECHNOLOGY SYDNEY (UTS) FACULTY OF LAW

The UTS Faculty of Law is a dynamic and innovative law school. Since its commencement in 1977 it has achieved great success for the quality of its legal education and its commitment to practice-oriented learning. In more recent years it has built a strong reputation for research excellence, engagement, and researcher development.

Dr Linda Steele (Senior Lecturer, Faculty of Law), and co-author of this Submission, is a socio-legal researcher working at the intersections of disability, law and social justice. She has been researching disability law and social issues for over a decade, having previously been a solicitor with the Intellectual Disability Rights Service. Dr Steele teaches civil court procedure law and mental health and disability law. Dr Steele's research is focused on understanding law's complex and contradictory relationship to violence, reflecting on what this means for how we engage with legal methods (such as litigation, law reform and human rights advocacy) to achieve social justice for disabled people. She has particular expertise in law's role in enabling and redressing violence against disabled people, including in the contexts of reproduction and sexuality, criminal justice systems, disability residential settings, residential aged care, and segregated disability employment.

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ACRONYMS

ABS	Australian Bureau of Statistics
AGAC	Australian Guardianship and Administration Council
ACRC Final Report	Final Report of the Royal Commission into Aged Care Quality and Safety
ACRC Interim Report	Interim Report of the Royal Commission into Aged Care Quality and Safety
ACQSC	Aged Care Quality and Safety Commission
Aged Care Royal Commission	Royal Commission into Aged Care Quality and Safety
AHRC	Australian Human Rights Commission
ALRC	Australian Law Reform Commission
BPSD	Behavioural and Psychiatric Symptoms of Dementia
CAT	Convention Against Torture
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
COAG	Council of Australian Governments
CRPD	United Nations Convention on the Rights of Persons with Disabilities
DPO	Disabled People's Organisation
DPO Australia	Disabled People's Organisations Australia
DRC Interim Report	Interim Report of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
ECT	Electroconvulsive Therapy
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
LARC	Long acting reversible contraception
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme

NDISQSC	NDIS Quality and Safeguarding Commission
NDS	National Disability Strategy
NPM	National Preventive Mechanism
OPCAT	Optional Protocol on the Convention Against Torture
OPD	Organisations of Persons with Disabilities
PSS	Personal Safety Survey
RACF	Residential Aged Care Facility
Royal Commission	Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
Restrictive Practices Issues Paper	Restrictive Practices Issues Paper
Senate Institutional Violence Inquiry	Senate Inquiry into Violence, Abuse and Neglect Against People with Disability in Institutional and Residential Settings
Senate Sterilisation Inquiry	Senate Standing Committees on Community Affairs Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia
Special Rapporteur on Disabilities	Special Rapporteur on the Rights of Persons with Disabilities
Special Rapporteur on Torture	Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
Special Rapporteur on Violence	Special Rapporteur on Violence Against Women, its Causes and Consequences
STVP	Stop the Violence Project
UN	United Nations
UN CEDAW Committee	United Nations Committee on the Elimination of Discrimination Against Women
UN CRPD Committee	United Nations Committee on the Rights of Persons with Disabilities
WWDA	Women With Disabilities Australia

PURPOSE AND STRUCTURE OF SUBMISSION

This Submission from Women With Disabilities Australia (WWDA) is in response to the ‘*Restrictive Practices Issues Paper*’ of the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability*.

WWDA’s core argument in this submission is that restrictive practices per se, **whatever context, setting and reason for use** are violent and are in violation of human rights. Their use must be prohibited and redressed, and legal frameworks for substitute decision-making and compulsory treatment authorising restrictive practices must be abolished. This has been the position of WWDA for a number of years, and we continue to hold this position. Regulation, exceptions, minimisation, limitations, reductions etc. are not enough. Ultimately, such approaches still allow restrictive practices – and violence – to continue to be perpetrated on people with disability. Therefore, this submission focuses on an in-depth exploration of the violence of restrictive practices in order to demonstrate to the Royal Commission why nothing short of prohibition and redress of restrictive practices is absolutely necessary.

Please note that WWDA will be making a separate submission in relation to sexual and reproductive violence. This provides further information about the nature, impacts and legal frameworks of sexual and reproductive-related restrictive practices on women and girls with disability.

The submission is structured in eight major sections and includes two Appendices:

- Section 1:** Outlines WWDA’s **36** Recommendations in relation to restrictive practices.
- Section 2:** Provides background to the Royal Commission in relation to restrictive practices and violence against women and girls with disability.
- Section 3:** Identifies WWDA’s key concerns with the Royal Commission’s approach to date on restrictive practices.
- Section 4:** Discusses a gender-inclusive definition of restrictive practices.
- Section 5:** Discusses the violence arising from use of restrictive practices.
- Section 6:** Builds on Section 5 by discussing the violence associated with the legality of restrictive practices, and explains how the use and legality of restrictive practices constitutes gendered ableist legal violence.
- Section 7:** Provides an overview of an international human rights framework for responding to restrictive practices as violence against women and girls with disability.
- Section 8:** Provides brief responses to the questions in the Royal Commission’s Restrictive Practices Issues Paper, drawing on the discussion in Sections 4-7.
- Appendix 1:** Provides relevant and recent Concluding Comments from UN Treaty Bodies in relation to restrictive practices.
- Appendix 2:** Provides endnotes.

Along with the information provided in this Submission, WWDA draws the attention of the Royal Commission to the following key reports from Women With Disabilities Australia (WWDA), which we respectfully request be considered by the Commission as critical documents to support our Submission. These documents are provided as accompanying documents to our Submission, and they are:

1. Frohmader, C. (March 2013) [Dehumanised: The Forced Sterilisation of Women and Girls with Disabilities in Australia](#). WWDA Submission to the Senate Inquiry into the involuntary or coerced sterilisation of people with disabilities in Australia. Women With Disabilities Australia (WWDA), Hobart, Tasmania. ISBN 978-0-9876035-0-0.
2. Dunn, C. (2018) [The Sterilisation of Girls with Disability: The State Responsibility to Protect Human Rights](#). Women with Disabilities Australia (WWDA), Hobart, Tasmania.
3. Women With Disabilities Australia (WWDA) (2011) [Submission to the United Nations Special Rapporteurs regarding forced sterilisation in Australia](#). WWDA, Hobart, Tasmania.
4. Women With Disabilities Australia (WWDA) (2011) [Letter to the Australian Attorney – General Regarding the United Nations Request for a Formal Response to Allegations of Involuntary Sterilisation of Girls and Women with Disabilities](#). WWDA, Hobart, Tasmania.
5. Women With Disabilities Australia (WWDA) (2012) [‘Moving Forward and Gaining Ground: The Sterilisation of Women and Girls with Disabilities in Australia’](#). WWDA, Hobart, Tasmania.
6. Disability Rights Now 2019: [UN CRPD Review of Australia: CRPD Factsheet 6: Forced sterilisation of people with disability and people with intersex variations](#). WWDA, Hobart, Tasmania.
7. Women With Disabilities Australia (WWDA) (2001) [‘Sterilisation and Reproductive Health of Women and Girls with Disabilities’](#). A Report on The National Project conducted by Women With Disabilities Australia (WWDA). By Leanne Dowse with Carolyn Frohmader for Women With Disabilities Australia (WWDA). WWDA, Hobart, Tasmania.



1 RECOMMENDATIONS

1. RECOMMENDATIONS

Women With Disabilities Australia ('WWDA') submits that the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* ('Royal Commission') must approach the use and legality of restrictive practices as a significant aspect of the broader systemic problem of violence against women and girls with disability and as inextricably related to ableism and structural inequality, discrimination and segregation which are entrenched in law and society.

With this in mind, this Submission from WWDA makes a number of recommendations that encompass a range of areas and issues – including segregation and institutionalisation of people with disability; the use and legality of restrictive practices; legislative and policy frameworks; intersectionality, disability and gender; the National Disability Insurance Scheme (NDIS); safeguards, accountability and redress; and, research, education and data collection.

This section outlines WWDA's **36** recommendations on restrictive practices in two stages. It first outlines recommendations to Government that the Royal Commission can include in its Final Report, and then makes a series of recommendations about the direction and focus of the Royal Commission's work leading up to the Final Report. Sections 4-7 of this Submission provide context to and elaboration on these recommendations.

Recommendations to Government for Inclusion in Final Report

Ending the Use and Legality of Restrictive Practices

1. That the Royal Commission recommend the Australian Government develop and implement a national, time bound strategy and framework for:
 - (a) prohibiting use of restrictive practices and substitute decision-making in relation to people with disability in all settings and contexts;
 - (b) abolishing legal frameworks for use of restrictive practices and associated laws for substituted decision-making and compulsory treatment (including in guardianship and mental health legislation, and common law *parens patriae* doctrine);
 - (c) redressing restrictive practices in ways that are accessible, efficient and inclusive for people with disability who have been subject to restrictive practices (even if the use of restrictive practices was lawful); and
 - (d) providing necessary resources for people with disability to have access to housing, employment, education and recreation opportunities that will support inclusion and participation in the general community.

Such a strategy and framework must explicitly extend to non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion.

2. That the Royal Commission recommend the Australian Government establish a Redress Scheme that will provide redress for restrictive practices (including non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion) which must:
 - (a) explicitly extend to restrictive practices, including (1) non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion, (2) use of restrictive practices in historical and contemporary contexts; and (3) use of restrictive practices irrespective of their legality at the time;

- (b) extend beyond individual compensation and include structural redress that engages the community at large and is directed towards transformative change of legal, political and social contexts that give rise to violence;
 - (c) overcome all existing access to justice issues encountered by people with disability; and be developed through consultation with the disability community.
3. That the Royal Commission recommend the Australian Government, as a matter of urgency, withdraw its Interpretative Declarations on CRPD Article 12 (Equal recognition before the law), Article 17 (Protecting the integrity of the person) and Article 18 (Liberty of movement and nationality).
 4. That the Royal Commission recommend the Australian Government commit to ensuring that Aboriginal women with disability are afforded their fundamental human right to self-determination and to have meaningful involvement in decision making, development and evaluation of supports and systems that affect them, including in relation to prohibition and redress of restrictive practices and introduction of supported decision-making.

Ending Segregation and Institutionalisation

5. That the Royal Commission recommend the Australian Government develop and implement a national, time bound strategy and framework for:
 - (a) the closure of all segregated and closed settings for people with disability, including those operated by non-government and private sectors;
 - (b) provide necessary resources for people with disability to have access to housing, employment, education and recreation opportunities that will support inclusion and participation in the general community; and
 - (c) abolish substitute decision-making laws that enable restrictive practices to transform housing, employment, education and recreation opportunities in the general community into segregated and closed settings.

NDIS and Restrictive Practices

6. That the Royal Commission recommend the Australian Government legislate to *prohibit* – rather than *regulate* – restrictive practices in NDIS funded services. To this end, the Australian Government should amend the National Disability Insurance Scheme Act 2013 (Cth), repeal the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 and abolish State and Territory substituted decision-making laws which provide the regulatory framework for restrictive practices in NDIS funded services.
7. That the Royal Commission recommend, until such time that restrictive practices are prohibited, the NDIS Quality and Safeguarding Commission (NDISQSC) be required to take action against all NDIS registered providers of support in relation to unauthorised restrictive practices and the National Disability Insurance Scheme Act 2013 (Cth) should be amended to provide an accessible redress scheme for individuals subjected to unauthorised restrictive practices (including non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion).
8. That the Royal Commission recommend the National Disability Insurance Agency (NDIA), in consultation with women with disability and their representative organisations, urgently

develop a NDIS Gender Strategy and that this explicitly address restrictive practices, including non-consensual and coercive sterilisation, contraception, menstrual suppression and abortion.

9. That the Royal Commission recommend the Australian Government require the NDIA provide publicly accessible gender-disaggregated data across all its data collection processes and frameworks and data specifically on use of restrictive practices in relation to female NDIS participants and this include data on non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion.
10. That the Royal Commission recommend the NDIA, in consultation with people with disability and their representative organisations, develop a risk assessment process for identifying and responding to violence against women and girls with disability in NDIS funded services, including identifying and responding to use of restrictive practices (including non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion).

Residential Aged Care and Restrictive Practices

11. That the Royal Commission recommend the Australian Government develop and implement a national, time bound strategy and framework for:
 - (a) closure of residential aged care facilities (RACFs), including those operated by non-government and private sectors;
 - (b) provision of necessary resources for people with disability (including older people with disability) who reside in RACFs to have access to housing, employment, education and recreation opportunities that will support inclusion and participation in the general community; and
 - (c) removing the upper age limit on eligibility to access the NDIS.
12. That the Royal Commission recommend the Australian Government legislate to *prohibit* – rather than *regulate* – restrictive practices in RACFs.
13. That the Royal Commission recommend, until such time that restrictive practices are prohibited, the Aged Care Quality and Safety Commission (ACQSC) be required to take action against all RACFs in relation to unauthorised restrictive practices.
14. That the Royal Commission recommend the ACQSC, in consultation with women with disability and their representative organisations, urgently develop an Aged Care Gender Strategy.
15. That the Royal Commission recommend the Australian Government require the ACQSC provide gender-disaggregated data and data specifically on restrictive practices across all its data collection processes and frameworks.
16. That the Royal Commission recommend the ACQSC, in consultation with people with disability and their representative organisations, develop a risk assessment process for identifying and responding to violence against women with disability in RACFs, including identifying and responding to use of restrictive practices.

Safeguards and Accountability

17. That the Royal Commission recommend the Australian Government establish an independent, statutory, national protection mechanism under specific purpose legislation, and with broad functions and powers to protect, investigate and enforce findings in relation to all forms of violence, abuse, exploitation and neglect against all people with disability (including restrictive practices, notably non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion), regardless of the context or setting in which it occurs and regardless of who perpetrates it. This national protection mechanism should explicitly operate within a human rights framework and include, as a minimum, the following core functions:
 - (a) a ‘no wrong door’ complaint handling function – the ability to receive, investigate, determine, and make recommendations in relation to all complaints raised;
 - (b) the ability to initiate ‘own motion’ complaints and to undertake own motion enquiries into systemic issues;
 - (c) the power to make recommendations to relevant respondents, including Commonwealth and State and Territory Governments, for remedial action;
 - (d) the ability to conduct policy and programme reviews and ‘audits’;
 - (e) the ability to publicly report on outcomes of systemic enquiries and group, policy and programme reviews, or audits, including through tabling an Annual Report to Parliament;
 - (f) the ability to develop and publish policy recommendations, guidelines, and standards to promote service quality improvement;
 - (g) the ability to collect, develop and publish information, and conduct professional and public educational programs; and
 - (h) the power to enable enforcement of its recommendations, including for redress and reparation for harms perpetrated.
18. That the Royal Commission recommend the Australian Government abolish the National Disability and Neglect Hotline² and reallocate resources to the establishment of an independent, statutory national mechanism to protect, investigate and enforce findings in relation to all forms of violence, abuse, exploitation and neglect against people with disability, including those related to restrictive practices (including non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion).
19. That the Royal Commission recommend that Australian and State and Territory independent oversight bodies under the Optional Protocol on the Convention Against Torture (OPCAT) categorise group homes, RACFs, closed mental health units, forensic disability units, and broader residential facilities for people with disability as ‘places of detention’ under the OPCAT, and be monitored accordingly.
20. That the Royal Commission recommend, related to the preceding recommendation, the Commonwealth Ombudsman as co-coordinating National Preventive Mechanism (NPM) actively engage with women and girls with disability and DPOs to ensure their ‘inclusion and effective participation’ regarding the monitoring of all places where people with disability are detained.

Address Restrictive Practices in Initiatives on Gender-Based Violence and Discrimination

21. That the Royal Commission recommend the Australian Government develop and enact national legislation on prevention of all forms of gender-based violence, and this should extend to restrictive practices (including non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion).
22. That the Royal Commission recommend the Australian Government, through the Department of Prime Minister and Cabinet, Office for Women and in consultation with civil society, develop a National Gender Equality Policy Framework, and this should explicitly address restrictive practices (including non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion).
23. That the Royal Commission recommend the Australian Government's development of the new National Disability Strategy ('NDS') reflects Australia's obligations under the CRPD to address discrimination against women and girls with disability, including in relation to restrictive practices (including non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion).
24. That the Royal Commission recommend the Australian Government, along with State and Territory Governments, develop a coordinated, nationally consistent, gendered Violence Prevention and Response Strategy for People with Disability that facilitates active participation of people with disability and includes strategies for ending the use and legality of restrictive practices (including non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion).
25. That the Royal Commission recommend the Australian Government and State and Territory Governments strengthen anti-discrimination laws to explicitly recognise and address intersectional discrimination and structural discrimination, including its aggravating and compounding effects, so they can apply in the context of the use and legality of restrictive practices (including non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion).
26. The Royal Commission must recommend the Australian Government provide long-term support, including core support and resources for research, capacity building, and violence prevention, to human rights-based DPOs constituted by, of and for women and girls with disability.
27. That the Royal Commission recommend the Australian Government and State and Territory Governments develop, as part of educational curricula, a comprehensive suite of educational programs delivered across the life span directed towards preventing violence against people with disability, including violence from the use and legality of restrictive practices (notably non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion). The aims of this suite of programs should be:
 - (a) fostering and valuing diversity and inclusion;
 - (b) challenging ableism and intersecting forms of inequality and discrimination, including for women and girls with disability;
 - (c) building knowledge, skills and strengths in recognising rights to bodily integrity, and to be free from violence, abuse, neglect and exploitation;
 - (d) recognising and remembering injustices against people with disability and resistance and survival of the disability community;

- (e) celebrating the achievements of disability activism and the disability rights movement; and
- (f) increasing opportunities and participation in decision-making and in speaking up about rights.

Research, Education and Data Collection

- 28. That the Royal Commission recommend the Australian Government commission and adequately resource a comprehensive assessment, using intersectional research methodologies, on the situation and rights of women and girls with disability in Australia, including specifically in relation to restrictive practices (notably non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion). This national intersectional research process must include specific experiences of those who are Indigenous, those from culturally and linguistically diverse backgrounds, those who are migrants, refugees or asylum seekers, and those from LGBTIQ+ communities.
- 29. That the Royal Commission recommend Australian Government and State and Territory Governments implement a nationally consistent framework to enable the collection, analysis and public reporting of disaggregated data across all jurisdictions, on all forms of gendered disability violence, abuse, neglect and exploitation experienced by women and girls with disability, including specifically in relation to restrictive practices (notably non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion).
- 30. That the Royal Commission recommend the Australian Government ensure data on violence against women with disability is systematically collected under the National Data Collection and Reporting Framework (for family, domestic and sexual violence), including specifically in relation to restrictive practices (notably non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion).
- 31. That the Royal Commission recommend that all courts and tribunals regulating restrictive practices, including state and territory Supreme Courts, guardianship tribunals and mental health tribunals be subject to greater levels of public transparency and accountability on their decisions on restrictive practices, including through public access to their decisions and quantitative data in relation to restrictive practices.

Recommendations for the Royal Commission's Work

Approach Restrictive Practices as Violence

- 32. That the Royal Commission's exploration of restrictive practices begins from the premise that restrictive practices (including non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion) are a form of violence.

Take a Gender-Inclusive and Intersectional Approach to Restrictive Practices

33. That the Royal Commission examine the nature, effects and impacts of restrictive practices on women and girls with disability, including seeking evidence directly from women and girls with disability.

Approach Restrictive Practices as Human Rights Violations

34. That the Royal Commission explicitly recognise the use and legality of restrictive practices as violating fundamental human rights, including the CRPD and other human rights treaties to which Australia is a party, and as a form of structural discrimination.

Explore Legality of Restrictive Practices

35. That the Royal Commission thoroughly explore the role of law (legal doctrine, legal processes, legal institutions and legal professionals) in perpetration of violence against people with disability through restrictive practices (including non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion).

Explore Redress for Restrictive Practices

36. That the Royal Commission explore redress (individual and structural/collective) for violence, abuse, neglect and exploitation associated with restrictive practices (including non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion).



2 BACKGROUND TO THE ROYAL COMMISSION AND OUR SUBMISSION

2. BACKGROUND TO THE ROYAL COMMISSION AND OUR SUBMISSION

- 2.1. This section provides background to the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (the Royal Commission) in relation to violence against women and girls with disability.
- 2.2. WWDA welcomes the opportunity to make this Submission to the Royal Commission in response to the '*Restrictive Practices Issues Paper*' (the Restrictive Practices Issues Paper).³ Please note, in coming months WWDA will be submitting to the Royal Commission a further submission on *Reproductive and Sexual Rights for Women and Girls with Disability*. This further Submission will include exploration of intersections of restrictive practices with reproductive and sexual rights.
- 2.3. This Submission in response to the Restrictive Practices Issues Paper, focuses on restrictive practices in relation to women and girls with disability. We use the term 'women and girls with disability' on the understanding that this is inclusive of women, girls, feminine identifying and non-binary people with disability in Australia. We use the term 'restrictive practices' on the assumption it includes non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion, forced removal of children, denial of support for sexual activity and denial of support for intimate relationships. We also assume it includes non-consensual and coercive use of psychotropic medication, even if the medication is prescribed by a medical practitioner for a diagnosed mental health condition, and involuntary detention and treatment in mental health facilities and community treatment orders pursuant to mental health legislation.
- 2.4. WWDA approaches restrictive practices as a form of gendered ableist legal violence against women and girls with disability that must be prohibited and redressed. WWDA is deeply concerned that restrictive practices continue to be widespread in practice and permitted by law. This is despite Australia ratifying seven international human rights treaties⁴ (all of which include obligations to persons with disability), (including the United Nations *Convention on the Rights of Persons with Disabilities* (CRPD)),⁵ numerous Government and law reform inquiries recognising systemic problems with restrictive practices, and increased commitment to addressing violence against women (including women with disability) during the last decade.
- 2.5. WWDA also recognises and emphasises that ending restrictive practices in relation to women and girls with disability cannot be achieved without understanding of, and targeted measures to address, underlying structural barriers that sustain the use and legality of restrictive practices. A key structural barrier is segregation of women and girls with disability in education, housing, and legal and justice systems. Ableism is also a key structural barrier that is deeply entrenched in law and society. Women and girls with disability need, and have a right to, implementation of specific, targeted measures to dismantle the many structural barriers that impede their right to live free from the violence of restrictive practices.
- 2.6. In this section, we situate the Royal Commission in a longer history of government inquiries into restrictive practices and a broader context of the dearth of information on restrictive practices.

The Failures of Past Inquiries into Restrictive Practices

- 2.7. The necessity for the Royal Commission and the high expectations WWDA holds for what it should achieve in relation to restrictive practices is underscored by failures of successive past inquiries into restrictive practices.
- 2.8. In the Australian context, there have been many Government inquiries and law reform reviews into restrictive practices over the past five to 10 years.⁶ Generally, these have recognised harms of restrictive practices and issues with decision-making and oversight of restrictive practices, including in the context of the CRPD. Yet, despite these multiple reviews and inquiries – and the significant amount of public monies expended on them – the reality is that these consistently fall short of recognising restrictive practices per se as violence and recommending prohibition and redress of restrictive practices. Instead, they have overwhelmingly recommended retaining legal frameworks enabling lawful use of restrictive practices and within these frameworks, reduction of use of restrictive practices via increased regulation through improved decision-making frameworks and enhanced oversight of disability and aged care service sectors using restrictive practices. These outcomes further entrench law’s complicity in the restrictive practices’ violence, a violence we describe as ‘gendered ableist legal violence’. Ultimately, these inquiries and their outcomes have not translated into any tangible action to prohibit and redress restrictive practices. Moreover, these reviews and inquiries (with the exception of the problematic 2013 Senate Sterilisation Inquiry)⁷ have generally failed to consider gendered dynamics of restrictive practices and have not explored the particular circumstances of women and girls with disability, including issues related to non-consensual and coerced sterilisation, menstrual suppression, contraception and abortion.
- 2.9. In 2013, the *Senate Community Affairs References Committee* reported on its inquiry into the *Involuntary or coerced sterilisation of people with disabilities in Australia*.⁸ In its report, the Committee observed that sterilisation was being used to manage a broad array of care issues by reason of ‘lack of appropriate and adequate support for both people with disabilities and their carers.’⁹ The Committee made a number of recommendations relating to access to education, training and information around sexuality and relationships for people with disability and their families, and medical and disability workers. It also recommended disability support planning that addressed support for menstruation as well as ‘support for relationships and sex education.’¹⁰ Yet, the report ultimately fell short of recommending prohibition of non-consensual and coercive sterilisation. Instead, the Committee recommended reforming the legal test for non-consensual sterilisation from ‘best interests’ to ‘best protection of rights.’¹¹ This proposed test focuses only on particular human rights, e.g. to health and inclusion and excludes the fundamental right of non-discrimination and equality. In its review of Australia in 2013, the UN CRPD Committee stated it was ‘deeply concerned that the Senate inquiry report ... puts forward recommendations that would allow this practice to continue.’¹² The Committee urged Australia to adopt ‘uniform national legislation prohibiting the sterilisation of boys and girls with disabilities, and adults with disabilities, in the absence of their prior, fully informed and free consent.’¹³ In its subsequent review of Australia’s compliance with the CRPD in 2019, the Committee once again reiterated these concerns and recommendations.¹⁴
- 2.10. In 2014, the Australian Law Reform Commission (ALRC) in its review *‘Equality, Capacity and Disability in Commonwealth Laws’* recommended a shift from substituted to supported decision-making. It recommended reform of Commonwealth, State and Territory laws consistent with four ‘National Decision-Making Principles’:

- (a) equal right to make decisions and have decisions respected;
- (b) provision of support persons for decision-making;
- (c) supported decision-making must be directed by the will, preferences and rights of individuals;
- (d) laws and legal frameworks must contain safeguards to prevent abuse and undue influence in decision-making.¹⁵

It also recommended introduction of the ‘Commonwealth decision-making model’ which consists of ‘supporters’ who provide support to an individual to make decisions and ‘representatives’ who are appointed (as a last resort and in limited circumstances) to make decisions for individuals based on their will and preferences because the individual desires or requires a third party decision-maker.¹⁶ It recommended that State and Territory Governments review their ‘*legislation that deals with decision-making to ensure laws are consistent with the National Decision-Making Principles and the Commonwealth decision-making model.*’¹⁷ The ALRC recommended the Australian Government and the Council of Australian Governments (COAG)¹⁸ take the ‘National Decision-Making Principles’ into account in the development of the national Quality and Safeguards system for NDIS disability services.¹⁹ It also recommended the ‘Australian Government and COAG adopt a similar, national approach to the regulation of restrictive practices in other relevant sectors such as aged care and health care’, as the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* requires States and Territories to reduce the use of restrictive practices.²⁰ While recognising submissions made by some Disabled People’s Organisations (DPOs) concerning sterilisation, the ALRC only noted these in the context of its discussion of State and Territory laws²¹ and did not make any recommendations about reform of the Commonwealth Family Law powers to authorise third party consent to sterilisation.

- 2.11. In its 2015 final report to its inquiry into *Violence, Abuse and Neglect against People with Disability in Institutional and Residential Settings*, the Senate Community Affairs References Committee considered ‘disability-specific interventions’, including restrictive practices.²² In relation to restrictive practices, the Committee expressed the view that ‘*the right to liberty is a fundamental human right. The committee is concerned with the extent to which restrictive practice is used, and is deeply concerned with the system which allows service providers to arbitrarily deprive people of their liberty.*’²³ It noted that ‘*[c]learly, in many cases what is deemed to be a necessary therapeutic or personal safety intervention is in fact, assault and unlawful deprivation of liberty.*’²⁴ The Committee expressed concern about use of restrictive practices in prisons and lower safeguards afforded in those settings as compared to disability services. It was of the view that the principles in the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* ‘*should apply to all institutions where people with disability are accommodated, particularly prisons*’²⁵ and expressed a similar view in relation to use of restrictive practices in schools.²⁶ The Committee did not express any views specifically in relation to restrictive practices specific to women and girls with disability such as non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion.
- 2.12 In considering the role of legal capacity in the violence of restrictive practices, the Committee expressed the view that:

At the heart of the issue of legal incapacity is the concept of decision-making for a number of reasons. First, when decision-making is removed from the hands of a person, it becomes easy for the decision-maker - whether it be parent, carer, or departmental officer - to then make decisions on behalf of

that individual that may seem ‘to be in their best interests’ but may actually be completely counter to the wishes of that person. Second, in every situation where a person has been forced to cede their own autonomy to another, there is the opportunity for abuse of that decision-making power. Finally, when the erosion of control from people with disability is normalised it makes it easier for society to accept that even those people with disability not subject to a legal guardianship order can have their will subverted as happens with the use of restrictive practices or forced medical treatments.²⁷

The Committee acknowledged the negative impacts of guardianship and its potential for abuse:

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

The guardianship process could be considered an abuse itself, particularly because of the loss of rights it entails.

In more serious cases, guardianship could be sought in order to enact abuse or neglect: Evidence has shown that even well-meaning guardians can inflict abuse or neglect through lack of understanding of their role or by being risk averse.

The fact that a vulnerable person may be prevented through guardianship arrangements from lodging a complaint is also a form of abuse. In many cases, the prevention of reporting violence, abuse and neglect leads to the indefinite perpetuation of inappropriate actions.²⁸

- 2.13. The Committee expressed agreement with the ALRC’s report and its recommendations about supported decision-making.²⁹ It indicated support for the ‘*implementation of a supported decision-making model that recognises a graduated continuum of legal capacity for people with disability*’.³⁰
- 2.14. In its 2016 final report on its Inquiry into *Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia*, the Senate Community Affairs References Committee³¹ considered restrictive practices³² and agreed with the views of the 2015 Committee’s inquiry into violence, abuse and neglect against people with disability in institutional and residential settings.³³
- 2.15. In 2018, the Australian Human Rights Commission (AHRC) released a report on safeguarding against violence in institutional settings (including institutional settings in the context of disability, health, mental health, aged care, justice, education, and child protection services).³⁴ It recommended quality, safeguarding and oversight mechanisms in the disability and mainstream sectors that take a human rights approach. In noting that restrictive practices violate human rights, the AHRC stated that it is ‘*important that the use of restrictive practices be eliminated wherever possible, and where they continue to be used they must be effectively regulated*’.³⁵
- 2.16. There have also been multiple reviews of State and Territory guardianship³⁶ and compulsory treatment laws³⁷ that provide legal frameworks regulating restrictive practices.

While many of these reviews have considered the CRPD and have indicated support for working towards eliminating use of restrictive practices, making recommendations for greater involvement of people with disability in substitute decision-making or even partial adoption of supported or assisted decision-making, none have gone so far as to recommend the complete abolition of substituted decision-making and prohibition of restrictive practices. Nor have any of them specifically recommended abolishing non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion.

- 2.17. There have been multiple reviews specifically in the context of aged care. The Senate Community Affairs References Committee report on *Care and Management of Younger and Older Australians Living with Dementia and Behavioural and Psychiatric symptoms of Dementia* in 2014 observed overuse of chemical and physical restraint and noted that *‘[i]t is necessary to make the necessary investments in training and facilities to ensure that the rights of people with dementia are respected and they are free from unnecessary restraints’*.³⁸ The Committee made various recommendations for monitoring restraint use.³⁹
- 2.18. In 2017, the ALRC released its final report on its inquiry into elder abuse.⁴⁰ It acknowledged that *‘use of restrictive practices will, in some circumstances, be elder abuse. Restrictive practices can deprive people of their liberty and dignity—basic legal and human rights. The practices might also sometimes amount to assault, false imprisonment and other civil and criminal wrongs.’*⁴¹ It recommended that *‘[a]ged care legislation should regulate use of restrictive practices in residential aged care’* and that restrictive practices should be the least restrictive option, used only as a last resort, proportionate to the risk of harm, be approved by a person authorised to make such decisions, be pursuant to a behaviour support plan and subject to regular review.⁴² It also recommended *‘consistently regulating the use of restrictive practices in aged care and the National Disability Insurance Scheme’*⁴³ and that the Australian Government consider amending aged care laws and legal frameworks consistently with the National Decision-Making Principles.⁴⁴ The ALRC stated that regulation would *‘mean that restrictive practices are used less frequently and only when appropriate, reducing one type of elder abuse and serving to protect older people’s legal and human rights.’*⁴⁵
- 2.19. Also, in relation to aged care, in 2017 and in the aftermath of the Oakden scandal,⁴⁶ the ‘Carnell-Paterson Review’ of aged care recommended restrictive practices only be used as a last resort and that providers be required to report on use of restrictive practices. It also recommended additional monitoring and approval of chemical restraint.⁴⁷ The subsequent House of Representatives Standing Committee on Health, Aged Care and Sport, *Report on the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia* in 2018 recommended the Australian Government amend the Aged Care Act 1997 to provide that *‘the use of restrictive practices in residential aged care facilities be limited to the “least restrictive” and be a measure of last resort only’*, that data on restrictive practice use be collected by Department of Health, that use of restrictive practices must be on the recommendation or prescription of a medical practitioner, and that following their use the guardian or family must be advised immediately.⁴⁸
- 2.20. In 2019, the Royal Commission into Aged Care Royal Commission released its interim report, *Neglect* (ACRC Interim Report). In hearing evidence of widespread use of restrictive practices, it attributed these to neglect:

Behind the use of these restrictive practices lies a history of neglect: neglect to engage adequately with older people to understand their needs and their concerns; neglect in being either time-constrained or unwilling to spend the time with older people to help them manage their changing behaviours so that

*the need for restraint is obviated; neglect in seeking permission for the use of restraints; and a surprisingly neglectful approach to the use and prolonged use of chemical restraint.*⁴⁹

The Aged Care Royal Commission stated in the ACRC Interim Report that, in its final report, it would ‘*address the regulatory framework as well as other measures designed to reform this neglected area of aged care.*’⁵⁰

- 2.21. In the Aged Care Royal Commission’s 2021 final report (ACRC Final Report), the Aged Care Royal Commission recognised the widespread problem of ‘substandard care’ and that ‘*[a]buse is an extreme example of substandard care and reaches into the realm of criminal behaviour.*’⁵¹ It noted that ‘*the number of people who have experienced substandard care is inexcusably high.*’⁵² The Aged Care Royal Commission stated that restrictive practices amount to abuse where they are used ‘*without clear justification and clinical indication*’, noting that: ‘*Not only do restrictive practices have questionable success in minimising changed behaviours, they can result in serious physical and psychological harm, potentially increasing health complications and, in some cases, can cause death.*’⁵³ It concluded that: ‘*The inappropriate use of unsafe and inhumane restrictive practices in residential aged care has continued, despite multiple reviews and reports highlighting the problem. It must now be stopped.*’⁵⁴ The Aged Care Royal Commission recommended reform to enhance regulation of restrictive practices, as it explained:

*Regulation of restrictive practices should be informed by respecting and supporting people’s rights, dignity and personal autonomy, while providing clarity about the circumstances in which care or treatment, including restrictive practices, may be authorised. We recommend that the Australian Government should amend the Quality of Care Principles 2014 (Cth) to provide that the use of restrictive practices in aged care must be based on an assessment by an independent expert. It should be subject to ongoing monitoring and reporting, with a behaviour support plan lodged with the Quality Regulator. Restrictive practices should only be used where alternative strategies to meet the person’s needs have been tried and found unsuccessful. Any exception that applies if a restrictive practice is necessary in an emergency should only apply for a short period, for as long as needed to prevent significant harm.*⁵⁵

- 2.22. Additional to improved regulation, the Aged Care Royal Commission recommended that use of restrictive practices in breach of the statutory scheme ‘*should be reportable under the updated serious incident reporting scheme*’. Moreover, ‘*any breach of the statutory requirements should expose the approved provider to a civil penalty at the suit of the regulator*’ and that persons directly affected by the breach and the aged care regulator should be able to seek an order for compensation for those persons directly affected.⁵⁶

- 2.23. It also recommended that:

*‘the Australian Government should consider the applicability to aged care of any findings from [the Disability Royal Commission] about restrictive practices and make further legislative amendments required to ensure that the treatment of people receiving aged care services is consistent with the treatment of other members of the community.’*⁵⁷

2.24. On a broader level, the Aged Care Royal Commission recommended a new aged care Act *'should specify a list of rights of people seeking and receiving aged care, and should declare that the purposes of the Act include the purpose of securing those rights and that the rights may be taken into account in interpreting the Act and any instrument made under the Act'*.⁵⁸ The rights include: *'the right to liberty, freedom of movement, and freedom from restraint'*.⁵⁹ In explaining this recommendation, the Aged Care Royal Commission states:

*'Typically, rights are supported by a related enforceable duty. With the exception of the right to freedom from restraint, we do not propose that each of the rights we list in Recommendation 2 should be separately and directly enforceable in the courts.'*⁶⁰

There is no further discussion of this enforceable right, nor its potential tension with the Aged Care Royal Commission's recommendation to continue regulating (rather than prohibiting) restrictive practices. Thus, it might be that this right will only apply to individuals who are subject to unlawful restraint.

2.25. This brief survey of past government inquiries into restrictive practices highlights the enduring approach to supporting use of restrictive practices on people with disability through regulating rather than prohibiting and redressing restrictive practices, and a persistent absence of consideration of the specific circumstances of women and girls with disability.

The Royal Commission

2.26. The Royal Commission⁶¹ was established after many years of campaigning by people with disability and our representative organisations at both the domestic and international level.⁶²

2.27. WWDA played a leading role in these advocacy efforts over many years, and in particular, in exposing the gendered nature of violence against people with disability.

2.28. In 2015, our collective campaign efforts led to establishment of the Senate Inquiry into *Violence, Abuse and Neglect Against People with Disability in Institutional and Residential Settings* (the Senate Institutional Violence Inquiry).⁶³ Recommendation 1 from the Senate Institutional Violence Inquiry was that a Royal Commission into violence against people with disability be established.⁶⁴

2.29. However, it was not until 2019, following further concerted advocacy efforts that the Royal Commission was finally established by the Australian Government. The urgent need for a Royal Commission into all forms of violence against people with disability was a key recommendation from the 2017 review of Australia's compliance with the *International Covenant on Economic, Social and Cultural Rights*, and was also addressed at the September 2019 review of Australia's compliance with the CRPD.

2.30. The Terms of Reference for the Royal Commission are contained in the Commonwealth Letters Patent that were signed by the Governor General on 4 April 2019. The Terms of Reference explicitly state that:

Australia has international obligations to take appropriate legislative,

*administrative and other measures to promote the human rights of people with disability, including to protect people with disability from all forms of exploitation, violence and abuse under the Convention on the Rights of Persons with Disabilities.*⁶⁵

2.31. The Terms of Reference reflect our campaign calls that the Royal Commission should have regard to ‘all forms of violence against, and abuse, neglect and exploitation of, people with disability, whatever the setting or context.’⁶⁶

2.32. The Terms of Reference also reflect our calls for recognition of intersectional dimensions of people with disability that make the experiences of violence, abuse, neglect and exploitation specific, unique and diverse:

*... the specific experiences of violence against, and abuse, neglect and exploitation of, people with disability are multi-layered and influenced by experiences associated with their age, sex, gender, gender identity, sexual orientation, intersex status, ethnic origin or race, including the particular situation of Aboriginal and Torres Strait Islander people and culturally and linguistically diverse people with disability.*⁶⁷

3.33. An intersectional analysis required by the Terms of Reference and enshrined in the CRPD is critical to ensuring that all forms of violence in all settings experienced by people with disability, including women and girls with disability is identified, understood and addressed.

2.34. Despite our collective calls for the Terms of Reference for the Royal Commission to include provision for a redress scheme, this was not included. In September 2019, the Committee on the Rights of Persons with Disabilities (the UN CRPD Committee) adopted its Concluding Observations following its review of Australia’s compliance with the CRPD. The UN CRPD Committee expressly recommended that the Australian Government: ‘ensure [adequate resources and] a redress mechanism for the Royal Commission.’⁶⁸ It remains unclear as to whether the Australian Government will adopt this critical recommendation. In its Group Homes hearing, the Royal Commission heard about the limited response of a disability service to violence against group homes residents. The Royal Commission observed in its interim report (DRC Interim Report): ‘it is clear that the question of redress, including compensation for serious harm, is worthy of further investigation.’ It went on to note that:

The Royal Commission proposes to investigate:

- *the forms of redress available to people with disability who are subjected to violence, abuse, neglect or exploitation while residing in group homes or supported accommodation;*
- *measures that should be taken to ensure that when violence, abuse, neglect or exploitation occurs, people receive independent advice and support to enable them to pursue the remedies available to them; and*
- *whether it is feasible to establish a scheme to compensate people with disability who have sustained serious harm from violence, abuse, neglect or exploitation in circumstances where no other redress is available to them.*⁶⁹

2.35. While it is encouraging that the Royal Commission identifies redress as an area of future exploration, it is yet to articulate the exact scope and focus of this work. We are concerned that its exploration of redress might be limited to contemporary residential settings and thus not cover contemporary instances of violence, abuse, neglect and exploitation in other settings and contexts, nor would it cover historical instances of violence, abuse, neglect and exploitation of people with disability in any setting or context. It is unclear whether the Royal Commission's exploration of redress will extend to restrictive practices given the group homes case study related to unlawful sexual and physical assault. Moreover, it is unclear what is meant by a redress scheme which would be available where 'no other redress is available to them', such as whether this would require an individual exhaust all court-based legal remedies (irrespective of the significant access to justice barriers experienced by people with disability). It is also unclear whether the redress scheme would cover restrictive practices which by reason of their lawfulness are an exemplar of violence, abuse, neglect and exploitation where 'no other redress is available'. WWDA supports the broadest possible exploration of redress, across all forms of violence, abuse, neglect and exploitation (including restrictive practices and other forms of legal violence), across all settings contexts (not only residential settings), and across all time periods (contemporary and historical).

Dearth of Empirical Data, Research and Studies on Restrictive Practices and Women and Girls with Disability

2.36. There is a dearth of data, research and studies on violence against women and girls with disability, notably disaggregated data, research and studies. In particular, there is an absence of data, research and studies on restrictive practices and women and girls with disability. This makes it extremely difficult to understand the nature and scope of restrictive practices as violence against women and girls with disability, and identify the necessary specific measures for violence prevention, response and redress.

2.37. The dearth of data, research and studies on restrictive practices and women and girls with disability has three implications for how the Royal Commission might approach its work on restrictive practices:

- The Royal Commission can use its powers and resources to quantify violence, abuse, neglect and exploitation in the form of restrictive practices, rather than relying on existing data.
- This quantification can be the use and legal authorisation and regulation of restrictive practices, with the latter requiring data collection from courts, tribunals, health departments, public guardians, disability and aged care services.
- This quantification must extend to non-consensual and coercive sterilisation, contraception, menstrual suppression and abortion, noting that contraception and menstrual suppression are not necessarily always captured in NDISQSC data collection or regulatory frameworks on restrictive practices.

2.38. As we discuss in the context of human rights in Section 7, the production of data, research and studies on restrictive practices and women and girls with disability is a human rights obligation in terms of domestic implementation of the CRPD, the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW), and other human rights treaties to which Australia is a party. Moreover, as Jessica Cadwallader and others explain, data has an important role in legal and political accountability, and in community recognition of the violation and humanity of people with disability:

Data is essential for political accountability. Violence against people with disability – 18% of the Australian population – is endemic, yet data about it is largely missing.

This lack of data impedes the development of effective policies and programs to prevent and respond to violence against people with disability. It also hampers advocacy efforts.

The lack of data lets governments, services and the community – all of us – off the hook. ...

We count what matters, and what matters counts. This is at the heart of accountability. We need information on the types of violence, where it occurs, how often, and who are the perpetrators.

People with disability need to be at the forefront of defining violence to ensure we capture the full complexities of their experiences. ...

These improvements would help us properly understand the extent of the violence. We could then respond better to the pervasive and hidden human rights violations against some of the most marginalised people in our community.⁷⁰

Lack of Data on Use of Restrictive Practices

- 2.39. It is now well established that violence against women and girls with disability globally and in Australia is far more extensive, frequent and significantly more diverse in nature than violence amongst either their male counterparts or women and girls without disability.⁷¹
- 2.40. It is widely recognised that any available data relating to incidence and prevalence of violence against women and girls with disability does not give the true picture of the level of risk and prevalence of violence and abuse due to many factors and barriers to reporting violence that are experienced by women and girls with a disability. Just some of these factors include, for example: the reinforced demand for compliant behaviours; the perceived lack of credibility; social isolation; lack of access to learning environments; lack of awareness of rights and what constitutes violence, abuse, neglect and exploitation; dependence upon others; fear of losing services; lack of access to police, support services, lawyers or advocates; lack of public scrutiny of institutions; and the entrenched sub-culture of violence and abuse prevalent in institutional and/or segregated settings.⁷²
- 2.41. Whilst it is recognised in research that ‘the nature of the experience of violence is intensified in frequency, extent and nature when gender and disability intersect’,⁷³ the available data, research and evidence about this experience is lacking. Where it does exist, it is largely focused within the area of domestic and family violence and conceptualised within a narrow framework and discourse of spousal and/or intimate partner violence.⁷⁴ This narrow focus does not reflect contemporary understandings of what constitutes gender-based violence, nor the complexity of the myriad forms it takes, and the settings in which it occurs in relation to women and girls with disability. As a result, other forms of violence against women – particularly those perpetrated against women and girls with disability – become obscured, resulting in their marginalisation in, and exclusion from, legislation, policies and service responses designed to address and prevent violence against women.⁷⁵

- 2.42. This dearth of data and research evidence is apparent in relation to restrictive practices. As noted by the Centre for Research Excellence in Disability and Health, restrictive practices do not fall within data collection on domestic and family violence.⁷⁶ Data collection on restrictive practices do not disaggregate according to gendered dynamics, such as use on women and girls with histories of victimisation and trauma, and use in the form of non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion. While research studies have begun to focus on the experience of violence for women and girls with disability over the past decade, the focus of these studies has largely been on the incidence and experiences of women with disability in the area of domestic and family violence.⁷⁷ For example, the Australian Bureau of Statistics (ABS) Personal Safety Survey (PSS) is the key Australian data asset that collects information on the nature and extent of violence experienced by men and women aged 18 years and over.⁷⁸ The 2016 PSS found that women with disability were more likely to have experienced violence in the preceding 12 months than women without disability.⁷⁹ However, the PSS's sampling frame includes only people living in private dwellings and excludes residential care and institutional facilities, such as group homes. WWDA is not aware of any statistical collections, where the Commonwealth is a data custodian, which specifically collects data on experiences of violence for women and girls living in non-private dwellings, or their experience in segregated environments/settings such as Australian Disability Enterprises, and other forms of congregate care settings.
- 2.43. A national survey undertaken in 2013 as part of the COAG Reform Project 'Stop the Violence' (STVP) found that violence is present in the lives of approximately twenty-two per cent of women and girls with disability who had accessed service support⁸⁰ in the preceding 12 months. The main types of violence experienced by the women included: domestic violence (80%); emotional abuse (68%); sexual violence and abuse (63%); financial abuse (58%); the withholding of care (23%); and the withholding of medication (14%). Importantly, findings from the survey provided data only on women and girls with disability who had accessed services. However, current literature, Australian Government reporting on the service use of people with disability, and reports from family violence services⁸¹ and women with disability themselves suggest that many women and girls with disability do not and/or cannot and/or are prevented from using and/or accessing services. As highlighted by STVP, it is highly likely that significant numbers of women and girls with disability who are experiencing or at risk of violence do not access any type of service. This suggests that the prevalence of violence against women and girls with disability is likely to be substantially higher than the already alarming 22 per cent suggested by the STVP national survey findings.
- 2.44. Nevertheless, there remains a significant lack of disaggregated data, research and information across all life domains that prevents the development of a comprehensive evidence base on violence experienced by women and girls with disability in Australia. This results in women and girls with disability being largely excluded from policies, programs, services and measures to progress gender equality.⁸²
- 2.45. Furthermore, there is little to no intersectional analysis, research or disaggregated data that examines the experience of violence, abuse, neglect and exploitation of specific groups of women and girls with disability, such as those who are Indigenous, those from culturally and linguistically diverse backgrounds, those who are migrants, refugees or asylum seekers, those who are lesbian, gay, bisexual, transgender or intersex, or those living in rural and remote communities.⁸³

- 2.46. While Australia has an existing and continually evolving national data landscape on violence against women, national datasets (surveys, longitudinal datasets and administrative data) have limitations in reference to violence against women and girls with disability. These limitations include: challenges in extrapolating comprehensive evidence on prevalence and perpetration rates for this particular cohort; challenges with how data is collected, what is collected, how surveys are methodologically designed and administered; and how existing data is leveraged for the creation of new data assets.⁸⁴
- 2.47. For more than a decade, the UN has been critical of Australia for its neglect of women and girls with disability in all aspects of data collection, information and research,⁸⁵ and has repeatedly called on Australian Governments to address this neglect as a matter of urgency. For example, following her mission to Australia, the Special Rapporteur on Violence Against Women, its Causes and Consequences (Special Rapporteur on Violence Against Women) recommended the Australian Government:
- Implement the recommendation made by the Committee on the Rights of Persons with Disabilities that the Government commission and fund a comprehensive assessment of the situation of girls and women with disabilities, in order to establish a baseline of disaggregated data against which future progress towards the implementation of the Convention could be measured.*⁸⁶
- 2.48. These strong recommendations from the UN are consistent with recommendations made to successive Australian Governments by civil society organisations, parliamentary inquiries and other fora.⁸⁷ Yet to date, this long-standing recommendation made by various UN bodies has not been enacted. There has been little progress in this area, and women and girls with disability continue to be excluded from policies, programs, services and measures to progress gender equality – including in relation to restrictive practices and the right to freedom from all forms of violence.
- 2.49. The UN has also clarified that Article 31 of the CRPD (Statistics and Data Collection) is not solely concerned with the collection of demographic statistics on prevalence and types of disability or impairment, but also with data on the extent of compliance or otherwise with the requirements of the Convention. It is inherently difficult for States Parties to report on CRPD implementation without benchmarking data on initial levels of compliance. The UN has subsequently made it clear that Australia must develop nationally consistent measures for data collection and public reporting of disaggregated data across the full range of obligations contained in the CRPD, and that all data must be disaggregated by gender.

Lack of Data on Restrictive Practices Legal Decision-Making

- 2.50. Additional to the absence of data, research and evidence on the use of restrictive practices, there is an absence of data, research and evidence on the legal authorisation and regulation of restrictive practices such as judicial/tribunal decision-making on use of restrictive practices or appointment of substitute decision-makers, and bureaucratic administration of substituted decision-making and compulsory treatment.
- 2.51. In particular, contrary to the principle of open justice (i.e., public access to the work of the courts), there is a lack of data, research and evidence on the proceedings of courts and tribunals regulating restrictive practices (e.g., state/territory Supreme Courts, guardianship tribunals and mental health tribunals).⁸⁸ This is because even though open justice in the Australian court system is a ‘fundamental rule of the common law’⁸⁹ enabling transparency

without which ‘abuses may flourish undetected’,⁹⁰ there is an established exception for courts applying the common law doctrine of *parens patriae*. This was explained in *Hogan v Hinch*:

It has long been accepted at common law that the application of the open justice principle may be limited in the exercise of a superior court’s inherent jurisdiction or an inferior court’s implied powers. This may be done where it is necessary to secure the proper administration of justice. ... The jurisdiction of courts in relation to wards of the State and mentally ill people was historically an exception to the general rule that proceedings should be held in public because the jurisdiction exercised in such cases was “parental and administrative, and the disposal of controverted questions ... an incident only in the jurisdiction.”⁹¹

2.52. We discuss the gendered and ableist nature of the common law doctrine of *parens patriae* in Section 6. For present purposes, greater public access to the work of courts applying the common law doctrine of *parens patriae* in the context of restrictive practices, and tribunals that are a modern legislative evolution of the common law doctrine. Such access is central to enhanced transparency and accountability of the justice system which, through its regulation of restrictive practices, is engaged in making decisions that can cause considerable harm to people with disability (see discussion of legal violence in Section 6). With little information, it is difficult for DPOs, advocates and academics to construct a systemic, empirical picture of the role of legal doctrine, legal process and legal institutions in the violence of restrictive practices. Traditionally, the justification for departing from the principle of open justice in relation to courts applying the common law doctrine of *parens patriae* has been the sensitivity of the matters considered in these hearings and vulnerability of people with disability. Yet, these traditional justifications reflect ableist assumptions about people with disability as helpless, needing protection and unable to make their own decisions. They also implicitly reflect assumptions that the court/tribunal processes are inherently benevolent and in the best interests of people with disability, such that the conventional suspicion of State authority underpinning the principle of open justice is not as significant in this context as other contexts (such as the criminal justice context). Removing transparency from legal decision-making itself exposes people with disability to vulnerability. Moreover, confidentiality of court and tribunal processes pertaining to restrictive practices replicates the kind of secrecy that is also central to the flourishing of violence in segregated and closed settings. Ultimately, situating legal decision-making relating to restrictive practices outside of the principle of open justice shows how the legal process through which legal decisions on regulation of restrictive practices itself subjects people with disability to segregation and discrimination in the justice system.⁹²



3 MOVING FORWARD: KEY AREAS OF ACTION FOR THE ROYAL COMMISSION'S WORK ON RESTRICTIVE PRACTICES

3. MOVING FORWARD: KEY AREAS OF ACTION FOR THE ROYAL COMMISSION'S WORK ON RESTRICTIVE PRACTICES

- 3.1. In this section we make some suggestions for the Royal Commission's future work on restrictive practices. In Sections 4-7 we pick up many of the points driving these concerns when we explore issues for women and girls with disability associated with the definition of restrictive practices, and the use and legality of restrictive practices.

Centring Experiences and Perspectives of Women and Girls with Disability

- 3.2. First, it is important that in future work the Royal Commission centres the experiences and perspectives of people with disability, including women and girls with disability.

- 3.3. Term of Reference (g) directs the Commissioners to have regard to:

*the specific experiences of violence against, and abuse, neglect and exploitation of, people with disability are multi-layered and influenced by experiences associated with their age, sex, gender, gender identity, sexual orientation, intersex status, ethnic origin or race, including the particular situation of Aboriginal and Torres Strait Islander people and culturally and linguistically diverse people with disability.*⁹³

- 3.4. Commissioner Sackville, Chair of the Royal Commission, states in his Foreword to the Royal Commission's 'Accessibility and Inclusion Strategy' that the Royal Commission is committed 'to putting people with disability at the forefront of its work'.⁹⁴ The Strategy states:

*Women and girls with disability are far more likely to experience violence and abuse than women and girls without disability, and they are less likely to report this abuse for both personal and systemic reasons. We provide a confidential and supportive environment for women and girls to engage with us.*⁹⁵

- 3.5. Addressing the experiences of women and girls with disability is particularly important because Australia has received numerous recommendations from the United Nations (UN) to investigate, address and remedy the high incidence of violence against women and girls with disability. Very few of these recommendations have been implemented by successive Australian Governments.
- 3.6. In order for the Royal Commission to fully meet its Terms of Reference and its commitment to foregrounding people with disability in the specific context of restrictive practices, it must centre the voices and experiences of people with disability, including women and girls with disability. It is encouraging that the Royal Commission has scheduled a hearing for October 2021 on the 'health and safety of women and girls with disability'. We hope this hearing will centre the voices and experiences of women and girls with disability, including in the context of fully considering restrictive practices such as non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion. This hearing is a vital aspect of the Royal Commission's work of exploring intersectional dimensions of

women and girls with disability's experiences of violence, abuse, neglect and exploitation. However, in the meantime, the Royal Commission can thread intersectionality and specific experiences of women and girls with disability throughout its work, including all of its issues papers and public hearings.

- 3.7. The Royal Commission, in consultation with women and girls with disability and their representative organisations, can conduct stand-alone Public Hearings, as well as forums, roundtables and other engagement activities to examine the specific experiences of women and girls with disability in relation to restrictive practices – across and inclusive of all life 'domains', and areas, including sexual and reproductive rights. WWDA suggests that the Royal Commission consider establishing an expert advisory group of women and girls with disability and their representative organisations to provide advice on: the situation of women and girls with disability in all areas of examination; specific areas of examination that disproportionately impact on women and girls with disability; the process of examinations, findings and recommendations; and other related matters. The Royal Commission must provide safe and supportive spaces to enable women and girls with disability to engage with the Royal Commission without fear of retribution. This is consistent with CRPD General Comment 3⁹⁶ and CRPD General Comment 7.⁹⁷
- 3.8. Gender-neutrality can (and does) create and perpetuate the consequences of gender-based discrimination and can (and does) lead to misleading analyses of issues and/or inaccurate assessments of likely policy outcomes. WWDA hopes that the Royal Commission will formulate recommendations that specifically respond to women and girls with disability's specific experiences of violence, abuse, neglect and exploitation. To date there has been little focus on the intersection between disability and gender and there has been a lack of identification and deeper exploration of gendered dynamics and specific experiences of women and girls with disability. Although the DRC Interim Report's summary singles out the importance of focusing on culturally and linguistically diverse people with disability and First Nations people with disability,⁹⁸ it does not similarly identify a priority focus on women and girls with disability nor identify the importance of examining intersectional gender issues related to culturally and linguistically diverse people with disability and First Nations people with disability.
- 3.9. WWDA hopes that in the Royal Commission's future work on restrictive practices the Royal Commission decentres the voices and experiences of academic, bureaucrat and professional experts including those who support the use of restrictive practices. Noting the Royal Commission's recognition of the role of discriminatory and stigmatising community attitudes about disability⁹⁹ and its aspiration (in the words of Commissioner Sackville) to 'transform community attitudes and bring about changes to policies and practices',¹⁰⁰ in its future work the Royal Commission must take an approach that does not take experts' opinions on restrictive practices at face value and instead questions and challenges their perspectives and the epistemic frameworks that shape their thinking and practice on restrictive practices. The Royal Commission can take the opportunity to identify the legal, cultural and economic dynamics that currently sustain the conventional status quo in law, medicine/health and disability services of restrictive practices as protective and non-violent (including in relation to non-consensual and coercive contraception and menstrual suppression which we understand is widely used and poorly regulated in disability services). Moreover, noting the powers given to the Royal Commission, it might consider calling professionals and service providers as witnesses under oath and compel them to give evidence in relation to their role in the use of restrictive practices (including non-consensual and coercive sterilisation, contraception, menstrual suppression and abortion).

- 3.10. Noting the Royal Commission's commitment to a 'life-course approach' and to intersectionality, WWDA is concerned about the absence of consideration of the experiences of older women with disability who are in RACFs. This is important for a number of reasons: the overwhelming majority of people in RACFs have disability, there are more women than men in the aged care system, there is a high incidence of sexual violence against women in RACFs, and there is a high incidence of restrictive practices and other forms of violence in RACFs (notably against people living with dementia). In the DRC Interim Report, the Royal Commission explains it will avoid overlap with the Aged Care Royal Commission:

We seek to avoid overlap with the work of the Royal Commission into Aged Care Quality and Safety, which is now due to submit its final report in February 2021. Our examination of violence against, or abuse, neglect and exploitation of, older people with disability will be informed by the findings and recommendations in that final report. Nevertheless, it is important that we describe what we know about the extent of violence, abuse, neglect and exploitation experienced by older people with disability who continue to live at home.¹⁰¹

- 3.11. However, the Aged Care Royal Commission in its Final Report has failed to make recommendations to prohibit and redress restrictive practices in RACFs and has not fully considered the human rights implications of regulating restrictive practices. In general, the Aged Care Royal Commission was not driven by the organising concept of 'violence' (indeed, this concept is not used in its Final Report) and it did not have an explicit human rights framework. We thus request that the Disability Royal Commission fully consider the use and legality of restrictive practices in RACFs, alongside other settings and contexts. To exclude this context from its work and recommendations will sustain discrimination and segregation of older people with disability that we see in other policy contexts, such as the NDIS upper age limit on eligibility.

Taking a Gender-Inclusive Approach to Restrictive Practices

- 3.12. Second, it is important that in future work the Royal Commission explicitly considers restrictive practices in relation to women and girls with disability.
- 3.13. Term of Reference G clearly calls for the Royal Commission to examine the specific experiences of violence against, and abuse, neglect and exploitation of people with disability in relation to sex and gender.
- 3.14. Women and girls with disability experience particular forms of restrictive practices that are not perpetrated on men and boys with disability and are exposed to higher risk of violence, abuse and exploitation in closed settings where restrictive practices are often used. Women and girls with disability experience higher incidence of violence and of social disadvantage such as poverty, unemployment and homelessness, which can increase the risk of being in closed settings and subjected to restrictive practices.
- 3.15. As noted by the Royal Commission in the DRC Interim Report and by the UN CRPD Committee in its General Comment 3 (Women and girls with disabilities),¹⁰² women and girls with disability are more likely to experience violence than both men with disability and women and girls without disability.

- '[W]omen with disability are twice as likely to report an incident of sexual violence over their lifetime than women without disability (33% or 605,081 women with disability compared to 16% of women without disability)'¹⁰³
 - 'Over their lifetime, men with disability are 2.6 times as likely to report sexual violence compared to men without disability'¹⁰⁴
 - 'Since the age of 15, one in three women with disability report emotional abuse by a current or previous partner (37% or 712,076 women with disability compared to 20% of women without disability)'¹⁰⁵
 - 'While people with disability experience higher rates of stalking than people without disability, women with disability are most at risk of being stalked'¹⁰⁶
 - 'Women with psychological and cognitive impairments have very high rates of all types of violence, particularly physical violence, sexual violence, partner violence and emotional abuse'¹⁰⁷
 - 'One in two women (334,076 women) with psychological and/or cognitive impairment have experienced sexual violence in their lifetime.'¹⁰⁸
- 3.16. There is limited statistical data on restrictive practices, although 'electroconvulsive therapy (ECT) performed on involuntary persons (i.e.: without that person's consent) indicates that in Australia three times more women than men are subject to the practice, across all age cohorts.'¹⁰⁹ Similarly, there is limited statistical data on violence against First Nations women and girls with disability,¹¹⁰ including in the context of restrictive practices. However, based on available statistics about violence, it is likely that women and girls with disability do experience a high incidence of restrictive practices.
- 3.17. The Royal Commission must take a gender-inclusive approach to its exploration of restrictive practices as violence. Such an approach involves recognising and investigating as forms of restrictive practices: non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion, forced child removal and denial of support for sexual activity and intimate relationships. This approach also involves thoroughly exploring connections between sexual and domestic violence and restrictive practices, particularly in light of the high incidence of sexual and domestic violence in women and girls with disability. This exploration should extend to:
- the role of restrictive practices in facilitating and concealing sexual and domestic violence against women and girls with disability;
 - use of restrictive practices as a service response to 'challenging behaviour' or 'behaviours of concern' where these behaviours are actually associated with current experiences of violence or trauma of past experiences of violence, notably sexual violence; and
 - the traumatising effects of restrictive practices.
- 3.18. WWDA encourages the Royal Commission to seek out data on restrictive practices (including disaggregated data in relation to gender) from all relevant authorities so this data can inform its work. Where data collection is not taking place (or is not sufficiently disaggregated) the Royal Commission must make recommendations requiring data collection and public access to data.
- 3.19. Despite Term of Reference G, which clearly calls for the Royal Commission to examine the specific experiences of violence against, and abuse, neglect and exploitation of, people with disability in relation to sex and gender,¹¹¹ to date the Royal Commission's

work on restrictive practices has not considered the specific situation of women and girls with disability. In the Restrictive Practices Issues Paper there is concerning omission of any reference to the specific situation of women with disability. Moreover, there is no consideration in the Restrictive Practices Issues Paper of First Nations women and girls with disability or culturally and linguistically diverse women and girls with disability, even though these are populations that the Royal Commission has committed to prioritising in its work:

The Royal Commission is also interested in the multi-layered experiences of people with disability of different age, sex, gender identity, sexual orientation and race. In particular, we will look at the experiences of First Nations people with disability and culturally and linguistically diverse people with disability.¹¹²

3.20. Consideration of restrictive practices must be mindful of the diversity of women and girls with disability. Over two-million women and girls with disability live in Australia (approximately 20% of the population of women), including approximately 100,000 girls with disability aged 0-14 and two-million women with disability aged 15 and older.¹¹³ Women with disability in Australia come from a range of backgrounds, lifestyles, beliefs and communities. They may be Indigenous or come from culturally and linguistically diverse communities. They may have a faith, or not; be married, divorced, partnered, or single; gay, lesbian, bisexual, transgender or intersex; parents, guardians, carers, and friends. They may or may not be in paid work, or they may be engaged in education and training. Each of these contexts can affect how, when, why, and in what form a woman with disability accesses, receives and/or is denied, services and supports. Further, these contexts can also influence how or if, and to what extent, women and girls with disability are included in social, political, cultural and economic opportunities and participation in community life. Moreover, there are under-explored issues concerning restrictive practices specifically in relation to feminine identifying and non-binary people with disability.¹¹⁴

3.21. In 'Nature and extent of violence, abuse, neglect and exploitation against people with disability in Australia', a report commissioned by the Royal Commission, the Centre for Research Excellence in Disability and Health recognises the exclusion of sterilisation and other restrictive practices from conventional understandings of violence:

Currently, there is no consistent approach to defining or identifying violence, abuse, neglect and exploitation against people with disability in Australia. Information is mostly drawn from data collections that typically ask about forms of violence that are common across the population (e.g., physical and sexual violence; domestic and family violence). While these data tell us about the nature, extent and impact of some types of violence for people with disability in comparison to people without disability, they fail to capture additional behaviours and manifestations of violence that may be specific to, or even experienced exclusively by, people with disability.

This includes, for example, violence that is targeted at people with disability because of their perceived vulnerability (also known as hate, disablist hate or bias crimes); denial of treatment, required medication and/or specific aids; limiting access to social and other support services and exploitation/violation of bodily autonomy including forced or coerced sterilisation. Information about these less commonly understood expressions of violent, abusive, neglectful and exploitative behaviours and practices rely primarily on formal disclosure and recording and currently there is little to support understanding about its nature and extent.

*We encourage the Disability Royal Commission therefore to explore the full scope of what violence, abuse, neglect and exploitation means for people with disability; the way it is enacted through a diverse range of incidents, consistently as part of everyday experiences and through the operations of family structures, relationships, institutions, service delivery and policy and legislative settings.*¹¹⁵

- 3.22. While the Royal Commission and its commissioned researchers have no control over existing datasets, the Royal Commission could use its powers and resources to quantify violence, abuse, neglect and exploitation in terms of a more expansive approach that includes restrictive practices.
- 3.23. The Royal Commission's issues paper on health care and services for people with cognitive disability did not discuss non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion, in which the health system is complicit. The related Public Hearings on health care and services for people with cognitive disability.¹¹⁶ In the DRC Interim Report there are passing references to restrictive practices in relation to women and girls with disability: the absence of data on use of sterilisation¹¹⁷ and suggestions at a Royal Commission 'that some women with disability in group homes are subjected to forced contraception'.¹¹⁸ However, these issues are yet to be fully explored.
- 3.24. The necessity for the Royal Commission to take a gender-inclusive approach to restrictive practices must be understood in the context of longer-term marginalisation in government inquiries on restrictive practices of women and girls with disability and restrictive practices used specifically or primarily on women and girls with disability (as discussed earlier in Section 2).
- 3.25. Violence, abuse, neglect and exploitation of women and girls with disability cannot be confined to an examination of domestic and family violence, which is often the only area where there is focus on violence against women and girls. Women and girls with disability do experience domestic and family violence, but they also experience violence in different forms, contexts and settings. There needs to be recognition that experiences of women and girls with disability are integral to all areas examined by the Royal Commission, and that there will also be areas that disproportionately impact on women and girls, such as violations of sexual and reproductive rights, which must also be examined by the Royal Commission. It is vital to bring together disability and gender, and not simply re-frame violence against women with disability as a straightforward gender issue. This is because often research and policy on violence against women marginalises the experience of women and girls with disability.
- 3.26. Restrictive practices are an exemplar of the limitations of a narrow approach to violence against women and girls focused on domestic and family violence. Use of restrictive practices on women and girls with disability is often situated outside of conventional understandings of violence against women and girls focused on domestic and family violence for a number of reasons:
- Women and girls with disability fall outside of normative (even progressive/feminist normative) understandings of womanhood, femininity, sexuality and domesticity and thus they are situated outside conventional (even progressive/feminist normative) understandings of what it means to be a victim-survivor of violence against women and girls.

- Restrictive practices have a non-violent and therapeutic/medicalised name and are legal and thus they are situated outside of dominant criminal justice understandings of violence.
- Restrictive practices often take place in relationships and settings outside of intimate/family relationships and the family home and thus they are situated outside conventional sites and relationships of domestic and family violence.

3.27. The exclusion of restrictive practices from conventional understandings of violence against women and girls is further demonstrated by recent activist and policy initiatives that do not appear to consider restrictive practices:

- Abortion decriminalisation focuses exclusively on reforming crimes legislation that criminalises women for accessing abortion,¹¹⁹ while leaving unreformed the absence of criminalisation of non-consensual and coercive abortion, contraception and sterilisation of women and girls with disability by reason of different laws (e.g., common law exceptions to criminal and tortious assault for third party medical consent and emergency situations, coupled with the longstanding common law doctrine of *parens patriae* and related guardianship and mental health legislation that enables third party consent);
- Increased attention to obstetric violence as a form of violence against women focuses on violence against women perpetrated in the context of reproductive healthcare,¹²⁰ but has not explicitly considered non-consensual and coercive abortion, contraception and sterilisation of women and girls with disability that also occur in the context reproductive healthcare; and
- Law reform inquiries and legislative developments in relation to coercive control¹²¹ focus on ongoing psychological control in the context of intimate partners but it is unclear whether these laws will extend to control of women and girls with disability through non-consensual and coercive restrictive practices, including in contexts outside of intimate/domestic relationships such as disability services, and where these restrictive practices are permitted by law through substitute decision-making and compulsory treatment regimes.¹²²

An Unequivocal Approach to Restrictive Practices as Violence

3.28. Third, in its future work it is important the Royal Commission be unequivocal in its approach towards restrictive practices as violence.

3.29. The Royal Commission's working definition of 'violence' includes restrictive practices:

*Violence and abuse cover a range of behaviours towards people with a disability. These could include assault, sexual assault, constraints, restrictive practices (physical and chemical), forced treatments, forced interventions, humiliation and harassment, financial and economic abuse and significant violations of privacy and dignity on a systemic or individual basis.*¹²³

3.30. The preamble to the Royal Commission indicates it is tasked with preventing all forms of violence against people with disability (not only violence that is illegal under criminal law):

*all forms of violence against, and abuse, neglect and exploitation of, people with disability are abhorrent.*¹²⁴

And, the Term of Reference A:

*what governments, institutions and the community should do to prevent, and better protect, people with disability from experiencing violence, abuse, neglect and exploitation, having regard to the extent of violence, abuse, neglect and exploitation experienced by people with disability in all settings and contexts;*¹²⁵

- 3.31. WWDA welcomes the Royal Commission's willingness to engage with restrictive practices in the context of violence. However, the Restrictive Practices Issues Paper falls short of fully recognising restrictive practices as violence because it focuses on regulating and minimising, rather than prohibiting and redressing restrictive practices. For example, it asks:

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

- A. What rules and safeguards should be apply?
- B. Should the same rules apply to all people?

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

- A. What needs to change in laws and polices?
- B. What needs to change in the community and within organisations?
- C. What are the barriers to this change?¹²⁶

- 3.32. These questions do not comprehend prohibition through law of restrictive practices and are instead focused on modifying behaviour at the individual and organisational level within a context of the continued permissibility and regulation of restrictive practices (as we discuss in Section 8).

- 3.33. It would be a disappointing missed opportunity if the Royal Commission were to add its name to the long list of inquiries (discussed in Section 2) that have merely recommended minimising restrictive practices by tweaking regulatory frameworks.

An Unequivocal Approach to Use and Legality of Restrictive Practices as Human Rights Violations

- 3.34. Fourth, WWDA encourages the Royal Commission to take a strong and clear position on use and legality of restrictive practices as human rights violations.

- 3.35. The Preamble to the Terms of Reference recognise the right to enjoyment of human rights pertaining to freedom from all forms violence:

RECOGNISING that people with disability are: equal citizens and have the right to the full and equal enjoyment of all human rights and fundamental freedoms, including respect for their inherent dignity and individual autonomy. ...

*AND Australia has international obligations to take appropriate legislative, administrative and other measures to promote the human rights of people with disability, including to protect people with disability from all forms of exploitation, violence and abuse under the Convention on the Rights of Persons with Disabilities.*¹²⁷

- 3.36. However, in its Restrictive Practices Issues Paper the Royal Commission only goes so far as to suggest restrictive practices might violate human rights:

We are committed to the rights of people with disability. Australia is required under the UN Convention on the Rights of Persons with Disability to respect, protect and fulfil the human rights of people with disability. People with disability have a right to be free from violence and abuse, and torture or cruel, inhumane or degrading treatment. People with disability also have rights to physical and mental integrity, liberty and autonomy. The use of restrictive practices may conflict with these human rights.¹²⁸

- 3.37. This equivocal approach to restrictive practices and human rights is deeply concerning, and echoes a similar approach in previous government inquiries into restrictive practices which have failed to recommend prohibition and redress of restrictive practices (discussed in Section 2).

Situating Restrictive Practices in Structural Contexts

- 3.38. In its future work, the Royal Commission should situate its exploration of restrictive practices in broader structural contexts, rather than acutely focusing on restrictive practices as an isolated phenomenon.
- 3.39. It is recognised that to prevent violence against women and girls, viewed as a ‘significant social problem’, there needs to be ‘a large scale response’ to achieve a ‘social transformation.’¹²⁹ It is acknowledged that beliefs, behaviours and systems that excuse, justify or condone violence and inequality must be challenged and reformed. While there are criticisms about the adequacy of the response to prevent violence against women, the current response in Australia includes State and national laws, national action plans, political commitments and budget allocations, national surveys, national awareness raising campaigns, inquiries, and educational programs delivered as part of the school curriculum.¹³⁰ On the other hand, violence against women with disability is more often examined only in the context of the disability service system, the imputed ‘vulnerability’ of people with disability, the failure of policies and procedures, the lack of qualified and accredited staff and the lack of rigorous oversight and protective mechanisms. While these factors are important, rarely are underlying drivers of violence, abuse, neglect and exploitation of women and girls with disability – disability inequality and discrimination, medical/health and justice/legal systems complicity in violence and segregation – identified or acknowledged. Consequently, there is no recognition of the need for a social transformation to address this situation.
- 3.40. The Royal Commission explains in its Restrictive Practices Issues Paper that its life-course approach will consider the ongoing and intergenerational impacts of restrictive practices and use of restrictive practices at different life stages:

We want to better understand how people with disability have experienced violence, abuse, neglect and exploitation across their life. ...

Restrictive practices can have ongoing effects across their life. There may be points in a person’s life where they are at a higher risk of being subjected to restrictive practices. ...

A life-course approach recognises that all stages of a person’s life are connected. If a person with disability experiences violence or abuse at one

point in their life, it may affect them in later parts of their life. If a person has a traumatic life experience(s) early in life, this may affect how they experience the use of restrictive practices later in life. ...

A life-course approach also considers life experiences across different generations. ...

Many people continue to feel the effects of historical practices of restriction. We will consider experiences of systemic discrimination against First Nations people with disability. We will also consider the experiences of systemic discrimination against culturally and linguistically diverse people with disability.¹³¹

- 3.41. While this is a promising approach (including its recognition of the particular impacts on First Nations people with disability and people with disability from refugee communities), to date the Royal Commission's consideration of restrictive practices has decontextualized them from the broader context of individuals' life courses of violence, abuse, neglect and exploitation, and structures of oppression. This is particularly evident in the failure to consider the legal frameworks that enable restrictive practices, how restrictive practices are situated in structural discrimination, segregation and violence (including that entrenched in law) and how individuals experience these frameworks over their lives.
- 3.42. The risk for the Royal Commission is that the investigation of restrictive practices and outcomes proposed are narrowed to merely enhancing existing service systems, removing existing barriers and establishing or improving protective mechanisms, without identifying the overall social and legal transformation required to prevent violence against people with disability through restrictive practices, including against women and girls with disability. Moreover, an exploration of restrictive practices in relation to particular service settings and domains risks:
- ignoring the reality of the pervasive nature of violence, abuse, neglect and exploitation that can be experienced by people with disability across all domains and aspects of their lives, and the specific and unique forms of this violence for women and girls with disability;
 - failing to consider intergenerational dynamics of violence, abuse, neglect and exploitation;
 - failing to address the legal and regulatory frameworks that enable violence and situate it beyond redress;
 - failing to expose the underpinning cultural, social, legal and economic drivers or enablers of violence, abuse, neglect and exploitation in Australian law, policy and practice and within society in general. As outlined in this submission, ableism, and the resulting inequality and discrimination, including intersectional discrimination, is a key driver of all forms of violence against people with disability in all settings; and
 - failing to identify and address ableism in systems of knowledge that support the use of restrictive practices, such as in disability diagnostic frameworks, and in legal, medical, health and helping professional (e.g. social work) disciplines.
- 3.43. The establishment of the Royal Commission is an opportunity to go beyond investigation of life domains, the operation of service systems, the quality of support workers, and protective mechanism responses, and to undertake a comprehensive investigation of ableism, inequality and intersectional discrimination in Australian law, policy and practice. Further, it allows for exploration of community attitudes generally in order to explicitly expose and address the

underlying cultural, social, legal and economic drivers or enablers of violence against people with disability through restrictive practices. We suggest the Royal Commission take an approach that balances in-depth, nuanced examination of restrictive practices in relation to specific contexts, sites, populations and individual case studies with a broader examination of restrictive practices in relation to epistemologies and ontologies of disability, interconnected service systems and legal frameworks, longer term dynamics of control of people with disability and lifelong and intergenerational trajectories.

- 3.44. It is also important that the Royal Commission situate its exploration of restrictive practices in the context of cultural ideas about disability. We know from the past decade, since the coming into force of the CRPD, that the mere existence of human rights is not enough to convince law reformers and law and policy makers about the necessity of taking action in relation to restrictive practices (as demonstrated in the overview of past inquiries in Section 2). In part, this inaction is attributable to deep-set and persistent ontological assumptions about what disability is, who people with disability are and how they should be in their bodies and in the world, and epistemological assumptions about who has the authority to make these claims. These assumptions do not merely inform community opinions about disability (i.e. the views of the person on the street), they also set the parameters for the privileging of academic, bureaucratic and professional expertise on disability and restrictive practices. Debates around triaging and rationing in the current COVID-19 pandemic¹³² are but one iteration in a longer history of systemic ableism in health/medicine. Indeed, the issue of discrimination in the health system and by medical/health professionals was considered the Royal Commission's public hearings on healthcare: *Public Hearing 10: Education and Training of Health Professionals in Relation to People with Cognitive Disability* and *Public Hearing 4: Health Care and Services for People with Cognitive Disability*. As such, the Royal Commission must carefully analyse the specific attitudes towards disability and people with disability in the epistemic and ethical frameworks of medical/health, caring (e.g. social work) and legal disciplines and professions (even if these are framed in terms of scientific objectivity or humane benevolence).
- 3.45. Without a sound understanding of how society constructs disability, and the ways in which different systems and structures of oppression intersect to shape the experiences of discrimination and violence, it is more likely that those tasked with shaping or implementing policies will develop solutions better suited for short-term fixes instead of long-term structural change.



4 A GENDER-INCLUSIVE DEFINITION OF RESTRICTIVE PRACTICES

4. A GENDER-INCLUSIVE DEFINITION OF RESTRICTIVE PRACTICES

- 4.1. This section of WWDA's Submission introduces a gender-inclusive definition of restrictive practices which is central to our Submission.
- 4.2. The Royal Commission defines 'restrictive practices' as 'any action, approach or intervention that has the effect of limiting the rights or freedom of movement of a person',¹³³ this being similar to the definition of 'restrictive practice' in the NDIS.¹³⁴
- 4.3. WWDA defines restrictive practices as extending to interventions that are exclusively or primarily perpetrated on women and girls with disability. These include: non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion, forced child removal and denial of support for sexual activity and intimate relationships. We reiterate that these have not been identified as restrictive practices in the Restrictive Practices Issues Paper.
- 4.4. These interventions fit within the Royal Commission's definition of 'restrictive practices' because they limit rights to autonomy, personal integrity and freedom from violence and torture (in being non-consensual and coercive), as well rights to family, health and community inclusion (by limiting their capacity to reproduce, parent and have intimate relationships).
- 4.5. However, these interventions might not be readily viewed as restrictive practices, and arguably they do not currently fit within the definition of a 'regulated restrictive practice' under the NDIS.¹³⁵ Even so, there is no justification for not including them within the meaning of 'restrictive practice' for the purposes of the Royal Commission's work. Rather, it is likely these interventions have been excluded from understandings of restrictive practices because of the intersection of gendered and abled norms. By this we mean that exclusion of women and girls with disability from normative gendered roles of mother, menstruator, sexual being, coupled with the devaluing and stigmatising of their embodied experiences are often the target of restrictive practices in relation to women and girls with disability (e.g., menstruation, sexual activity, reproduction, parenting, trauma from sexual violence and abuse), means that it is self-evident, necessary and beyond politicisation that women and girls with disability would have their autonomy overridden and their capacity to reproduce, parent and have intimate relationships limited.
- 4.6. The current exclusion of non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion, forced child removal and denial of support for sexual activity and intimate relationships from the meaning of restrictive practices matters. This is because, in a context where these interventions are legally permitted, the failure to categorise them as restrictive practices means they are subject to less regulatory oversight.
- 4.7. Non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion, forced child removal and denial of support for sexual activity and intimate relationships not only violate personal integrity and autonomy when done non-consensually or coercively but have additional physical and psychological impacts.
- 4.8. Sterilisation includes a range of practices that have a permanent impact on reproductive capacity:

Sterilisation is a surgical operation or any other process that induces the permanent loss of reproductive capacity. For women, the most common and effective procedures are the hysterectomy, bilateral oophorectomy, tubal ligation and endometrial ablation. The most common procedure for girls with disability is the hysterectomy – removing the uterus and ceasing menstruation, yet continuing ovulation. Both bilateral oophorectomy and tubal ligation may be used in conjunction with a hysterectomy. A bilateral oophorectomy removes both ovaries. For a young woman with functioning ovaries this is a particularly serious operation, as it will cause a sudden termination of hormone production and commence menopause. She will need to undertake long-term hormone replacement therapy. Tubal ligation – blocking the female egg from proceeding down the fallopian tube - is less common as ovulation and menstruation will continue. A total hysterectomy may also be utilised, removing the uterus, ovaries, fallopian tube, cervix and upper vagina.¹³⁶

- 4.9. There are no reliable or consistent data on sterilisation.¹³⁷ In 2015, as an outcome of the Senate Sterilisation Inquiry,¹³⁸ the Australian Government commissioned the Office of the Public Advocate (Victoria) to undertake a national project on ‘sterilisation data collection practices’.¹³⁹ The national Project was focused on ‘sterilisation applications and medical procedures that result in sterilisation of adults with cognitive impairment across all state and territory jurisdictions’ and involved the ‘development of indicators to standardise the collection of data across jurisdictions.’ An outcome of the Project was the development of an agreed set of data indicators, and an excel data record template to assist Tribunals¹⁴⁰ to record and report on the endorsed data indicators. Tribunals commenced the data recording in 2016. Since then, the Australian Guardianship and Administration Council (AGAC) has released the ‘Australian Sterilisation Data Report’¹⁴¹ each year. The ‘Report’ is in the form of a one-page table listing the ‘number’ of tribunal and board-approved sterilisation of adults with cognitive impairment, by jurisdiction, in each financial year. It does not include applications and approvals for sterilisation made by the Family Court. It remains unclear as to whether Tribunals are required to provide the data to be included in the ‘Australian Sterilisation Data Report’, or whether this is a voluntary process. The Final Report of the ‘sterilisation data collection practices’ national Project, stated that:

Questions remain around how and when the Federal Attorney-General’s Department expects Tribunals to record and report on data and the authority for issuing any requirement to collect data, as well as who will be responsible for data collection and analysis.¹⁴²

- 4.10. Whilst there are obvious and clear limitations in the ‘Australian Sterilisation Data Report’ (including that it applies only to adults with cognitive impairment and it only counts decisions made by guardianship tribunals), the data provided by State and Territory Tribunals between June 2016-June 2020, show that **31** applications for sterilisation of adults with cognitive impairment were **approved**. This figure is likely to be significantly higher. The 31 ‘recorded approvals’ relate only to ‘adults with cognitive impairment’. The ‘Australian Sterilisation Data Report’ does not include any data related to children. In addition, as re-iterated in the Final Report of the ‘sterilisation data collection practices’ National Project:

[We] acknowledge the reality that involuntary and forced sterilisation of people with disability, particularly woman and children, still occurs outside of lawful authorisation processes, which likely constitutes a violation of the person’s human rights.¹⁴³

AGAC has, itself, acknowledged that the ‘reporting of forced sterilisation is not considered robust’.¹⁴⁴ The ‘Australian Sterilisation Data Report’ does not address the key Recommendation made by the Community Affairs References Committee in its Final Report of the Senate Sterilisation Inquiry:

*The Committee recommends that data about adult and child sterilisation cases be recorded, and reported, in the same way in each jurisdiction. Data records should include the number of applications made for a special medical procedure, the kind of special medical procedures specified in the application, the categories of parties to the proceedings (for example, parents, medical experts, public advocates), and the outcome of the case.*¹⁴⁵

- 4.11. There are numerous impacts of sterilisation on women and girls with disability, although the full range and extent of these is unknown due to a lack of research:

Forced sterilisation permanently robs women of their reproductive capacity, violates their physical integrity and bodily autonomy, and leads to profound and long-term physical and psychological effects, including: psychological pain, suffering, lifelong grief and trauma, extreme social isolation, family discord or breakdown, fear of medical professionals, social stigma, and shame.

*The long-term consequences of forced and coerced sterilisation practices commonly used on women and girls with disability remain under-researched. There are very few research studies, including longitudinal studies that investigate the physical, psychological, sexual and other social impacts of these procedures for women and girls with disability.*¹⁴⁶

- 4.12. Sterilisation may also lead to certain gynaecological cancers,¹⁴⁷ however there remains a dearth of research in this area.

- 4.13. Restrictive practices also take the form of menstrual suppression and contraceptive known collectively as ‘long acting reversible contraception’ (LARC). LARC involves use of drugs to prevent menstruation and/or reproduction. While LARC is ‘temporary’ in the sense that there is always the possibility for the drugs to be ceased and their impacts reversed, in practice they are often administered for years and decades with little medical review and scrutiny of their purpose, necessity and side effects on those to whom they are prescribed.¹⁴⁸ Furthermore, if women and girls with disability are deprescribed LARC, they can experience side effects such as physical pain which can provide perverse incentives to resume prescription.¹⁴⁹

- 4.14. There are no available data on LARC.¹⁵⁰ As we discuss in Section 5, these are widely used in disability services but are subject to incomplete regulation by the NDISQSC. Medication for menstrual suppression is only considered a form of chemical restraint and thus a regulated restrictive practice where it is used ‘due to behaviours of concern for example, distress and hygiene (e.g. smearing)’, and it will not be a chemical restraint when ‘prescribed for the treatment of a diagnosed medical condition’.¹⁵¹ In contrast, there are stricter limitations on use of anti-libidinal medications in the context of NDIS-funded services, including that ‘[a]nti-libidinal medications must not be used in males under the age of 18 years, or in other instances where bone and testicular development is not yet complete’.¹⁵² The lower threshold for use of LARC in relation to women and girls with disability is of significant concern. Moreover, WWDA is concerned with the division in NDISQSC approach to LARC between LARC for medical condition as opposed to for

behaviours of concern. WWDA is concerned because women and girls with disability are often viewed through a medical model and have their behaviour pathologised and this is compounded with the pathologisation of female experiences of menstruation and reproduction, such that it is arguably quite easy to frame LARC use as being related to a medical condition rather than behaviours of concern. This division between medical conditions and behaviours of concern is not scientifically objective – it is socially and economically contingent and gendered.

- 4.15. Additional to the impacts on personal integrity and autonomy, the impacts of LARC can include certain gynaecological cancers, osteoporosis, increased weight gain, elevated prolactin concentrations (which can cause infertility, menopausal symptoms, milk discharge from the breasts, hyperprolactinemia; hypothyroidism).¹⁵³ Moreover, because LARC prevent menstruation, they can also mask the onset of menopause which can then mean physical and psychological experiences associated with menopause are ignored¹⁵⁴ and potentially a basis on which women with disability are subject to further coercive interventions to manage their ‘challenging behaviour’ associated with onset of menopause or the pain of undiagnosed cancer or osteoporosis.
- 4.16. Restrictive practices also extend to non-consensual and coercive abortion, i.e. the termination of a pregnancy.
- 4.17. There are no available data on non-consensual and coercive abortion.¹⁵⁵
- 4.18. Additional to the impacts on personal integrity and autonomy, the impacts of non-consensual and coercive abortion include psychological pain, grief and suffering.¹⁵⁶
- 4.19. The psychological and physical impacts of non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion are compounded by lack of access to safe and non-discriminatory health and medical services including counselling, cancer screening, bone-density screening, pain management, and menopause support,¹⁵⁷ which is in turn compounded by use of restrictive practices in response to ‘challenging behaviours’ which are in fact expressions of untreated trauma, physical illness and disease, and hormonal changes.
- 4.20. Restrictive practices in relation to women and girls with disability also take the form of forced child removal. This can be:
 - (a) informal removal by the mother’s family members or the child’s other parent and that other parent’s family,
 - (b) formal removal by child protection services, or
 - (c) formal removal by the mother’s family members or the child’s other parent and that other parent’s family pursuant to a family law order. This form of restrictive practice has a particular impact on women who give birth to children and are often primary or sole caregivers.
- 4.21. There is no available data on informal forced child removal. There is no comprehensive data on formal child removal because data is not consistently collected on parental disability. However, there is a higher incidence of forced child removal by child protection services, and this is inextricably linked to discrimination in the child welfare system and care and protection justice system:

Women with disability the world over are discouraged or denied the opportunity, to bear and raise children.

They have been, and continue to be perceived as not having a sexuality, dependent, recipients of care rather than mutual care-givers, and incapable of looking after children. Conversely, women with intellectual disability in particular are often regarded as overly sexual, creating a fear of profligacy. These perceptions, although very different, result in women with disability being denied the right to reproductive autonomy and self-determination.

Women with disability considering having and/or raising a child are often subjected to the sceptical beliefs of family members, health workers, and even complete strangers, regarding their ability to care for a child.

In Australia, children of people with disability are subject to removal from their parents by authorities at a rate up to ten times higher than other parents. In many circumstances children are removed pre-emptively solely on the basis of the parent's disability (most often the mother), despite there being no evidence of any neglect, abuse and/or parental incompetence.

Women with intellectual disability who are parents, are scrutinised by health and welfare workers and held to higher standards than those that are applied to non-disabled women who are parents. The evidence used to judge potential for parental inadequacy is often based on unfair and invalid assessment procedures that are often carried out in unsupportive environments.

Mothers with disability are significantly overrepresented in child protection systems in Australia despite having the same capacity as other women to be effective parents.

Evidence demonstrates that parents with disability are no more likely to maltreat or neglect children than non-disabled parents.

Women with disability experience extensive discrimination in the justice system. A common impact of violence perpetrated against women with disability (particularly domestic and family violence) is the removal of their children by authorities on the basis of parental disability.¹⁵⁸

- 4.22. In 2013, the Australian Council of Human Rights Authorities (ACHRA) identified discrimination against 'potential and actual parents with disability' as "one of three most urgent and pressing human rights issues in Australia today." ACHRA recommended the Australian Government take urgent action on this discrimination against parents with disability, however this recommendation has not been implemented. The Communiqué from the ACHRA 2013 annual meeting stated, in part:

Finally, having regard to evidence: (a) that parents with disability are significantly overrepresented in child protection systems in Australia despite having the same capacity to be effective parents; (b) that there is a lack of systematic data collection and analysis; (c) that there is a lack of appropriate supports to potential and actual parents with disability, - ACHRA calls for better data collection and better research into negative presumptions being made about people with disabilities being able to effectively parent. ACHRA calls for better support for these parents to fulfil their parenting roles and has identified that this as a priority given the discriminatory impact of negative presumptions.¹⁵⁹

- 4.23. In its 2019 Concluding Observations of Australia,¹⁶⁰ the UN CRPD Committee expressed its serious concerns about: ‘Parents with disabilities having their child more likely removed, often on the basis of disability’ and ‘the lack of support in their exercise of parental responsibilities for their children’ and recommended that Australia:

Ensure no separation of children from parents on the basis of the disability of either the child or one or both of the parents; and

Adopt comprehensive and gender and culturally specific parenting and family support measures for parents with disabilities.

The CRPD Committee also expressed concern at ‘the reported discrimination, particularly of women with disabilities and LGBTIQ+ persons with disabilities in accessing assisted reproductive technologies’ and recommended that Australia implement all necessary measures to ‘ensure that women with disabilities and LGBTIQ+ persons with disabilities have equal access to assisted reproductive technologies.’¹⁶¹

- 4.24. The impacts of forced child removal include ongoing grief and trauma. Removal can also be associated with further use of restrictive practices, such as sterilisation:

Women with disability have been coerced to have hysterectomies after they have given birth to one or more children, who have usually been taken from their care; or as a condition of having access to their child who has been taken from their care.¹⁶²

- 4.25. Restrictive practices against women and girls with disability can also extend to denial of support for sexual activity and intimate relationships. Women and girls with disability might be more impacted by these sexual/relationship restrictive practices because they are less likely seen as sexual beings and are infantilised.¹⁶³
- 4.26. Denial of support for sexual activity includes disability support workers, family members or informal carers refusing to assist a woman with disability to access what they need to learn about and engage in sexual activity, including access to sex workers trained in working with women with disability and women experiencing trauma, sex therapists, or sex education. Denial of support for sexual activity is also facilitated at a systemic level by the denial of government funding to learn about and engage in sexual activity, such as the ongoing resistance of the Commonwealth government to support NDIS funding for sexual services, as demonstrated by recent media statements by Minister Stuart Robert trivialising the issue as disabled people wanting to spend public money on ‘prostitutes’¹⁶⁴ and NDIS litigation on this issue.¹⁶⁵
- 4.27. Denial of support for intimate relationships includes disability support workers, family members or informal carers refusing to assist a woman with disability to access what they need to learn about and engage in an intimate relationship, including preventing cohabitation with or preventing contact with an intimate partner and not supporting opportunities to meet potential partners.
- 4.28. It is also important to note the gendered dimensions of other restrictive practices that shape the perpetration, incidence and impacts of these. This is demonstrated by three examples.

- 4.29. One example is the use of psychotropic medication. There is a higher incidence of ECT in relation to women.¹⁶⁶ Women and girls might be more subject to certain diagnoses (such as bipolar, borderline personality disorder, anxiety and depression) that are associated with involuntary mental health detention and treatment, for such reasons as gendered norms of behaviour and the failure to recognise trauma related to sexual and physical violence.¹⁶⁷ It is important to note that psychotropic medication prescribed for treatment rather than influencing behaviour is not recognised as ‘chemical restraint’ in the context of NDIS funded disability services¹⁶⁸ and RACFs.¹⁶⁹ As we also noted in the context of LARCs, the line between psychotropic medication for treatment of a medical condition as opposed to behaviour is inherently problematic in the context of people with disability who are often viewed through a medical model and have their behaviour pathologised, this being exacerbated for individuals diagnosed with disabilities that have a behavioural component.
- 4.30. A second example is restrictive practices in the form of denial of access to food and drink (such as locking fridges and kitchen cupboards in group homes). These might be guided by gendered ideas of ideal bodies and the greater emphasis on slimness as beauty in relation to females. The denial of access to food and drink to women and girls with disability is particularly problematic given weight gain caused by psychotropic drugs or lack of exercise and recreation options in institutional settings.¹⁷⁰
- 4.31. A third example is the use of restrictive practices in institutional and segregated settings. Many women and girls with disability are subject to restrictive practices in institutional and segregated settings where they have limited access to police, support services, lawyers or advocates, and are trapped within the entrenched sub-culture of violence and abuse prevalent in institutional and segregated settings. In these settings they experience social isolation and lack of access to learning environments; are often economically, physically and psychologically dependent on others; and are socialised or compelled to tolerate a high degree of personal indignity, mishandling, and violence, abuse, exploitation and neglect as an incident of service delivery to them. For example, drawing on restrictive practices research from the UK, Maker identified four key areas of concern. The first is that staff decisions about use of restrictive practices and their broader interactions with service users are ‘implicitly or explicitly influenced by gendered expectations and stereotypes’, such as ‘women with intellectual disability and women with certain mental health diagnoses are manipulative and attention seeking.’¹⁷¹ Second, there is a focus on ‘approaches that downplay relationships and emotions and instead focus on “technological” solutions such as medication or treatment programmes.’¹⁷² Third, ‘the gender of staff, including those involved in restraint, is not considered to be relevant to the planning or delivery of services. This ignores the discomfort or concerns that both service users and staff may have about men’s involvement in restraining women, and the reality that men are more likely than women to commit sexual assault or other abuse on women.’¹⁷³ Fourth, women experience restraint as a form of punishment and control, and as physically and psychologically harmful, and as interrelated with pre-existing trauma.¹⁷⁴ It is also important to note that in relation to the institutional setting of RACFs where restrictive practices are endemic, there are more women than men.¹⁷⁵
- 4.32. Having introduced our broadened gendered definition of restrictive practices, we now turn to discuss how restrictive practices constitute violence against women and girls with disability through an exploration of the use and legality of restrictive practices.

A hand holding a white sign with the text "my body MY CHOICE" in bold, dark blue letters. The background is a blurred crowd of people in an outdoor setting, possibly a protest or public gathering. The sign is held up in the center of the frame, and the hand is visible at the bottom. The text is arranged in three lines: "my body" on the first line, "MY" on the second line, and "CHOICE" on the third line.

**my body
MY
CHOICE**

5 USE OF RESTRICTIVE PRACTICES

5. USE OF RESTRICTIVE PRACTICES

- 5.1. In this section we explore the violence arising from use of restrictive practices on women and girls with disability. We explain that this is a form of gendered ableist violence. By this we mean use of restrictive practices violate, harm, dehumanise and segregate women and girls who are subjected to them, negates their ways of being and knowing, and affirms gendered and abled norms that situate women and girls with disability outside girlhood and womanhood and full humanness.

Questioning the Conventional Rationales for Use of Restrictive Practices

- 5.2. The Royal Commission identifies two interrelated reasons for use of restrictive practices: to protect from harm and to control behaviour:

Restrictive practices can be used across Australia, as a last resort, to prevent or protect people from harm. This includes a perceived risk of harm. This may include preventing or protecting an individual or others from behaviours referred to as 'challenging behaviours' or 'behaviours of concern'.¹⁷⁶

- 5.3. This rationale for use is also reflected in the definition of 'regulated restrictive practices' in the NDIS:

A restrictive practice is a regulated restrictive practice if it is or involves any of the following:

(a) seclusion, which is the sole confinement of a person with disability in a room or a physical space at any hour of the day or night where voluntary exit is prevented, or not facilitated, or it is implied that voluntary exit is not permitted;

(b) chemical restraint, which is the use of medication or chemical substance for the primary purpose of influencing a person's behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition;

(c) mechanical restraint, which is the use of a device to prevent, restrict, or subdue a person's movement for the primary purpose of influencing a person's behaviour but does not include the use of devices for therapeutic or non-behavioural purposes;

(d) physical restraint, which is the use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person.

(e) environmental restraint, which restrict a person's free access to all parts of their environment, including items or activities.¹⁷⁷

- 5.4. The focus on protection and behaviour control suggests use of restrictive practices is self-evidentially for the benefit of the individual subject to them – that it is for their own safety and development and that they are used in extreme circumstances out of necessity and where there are no other options.
- 5.5. The conventional uses of restrictive practices are problematic in two respects.
- 5.6. First, there are problematic assumptions about the individual behaviour driving their use. ‘Challenging behaviour’ is a term which is only used in relation to people with disability. It is impossible to justify non-consensually drugging or sterilising someone else without disability simply because of their behaviour, and even where criminal conduct is present this is not a ground for drugging or sterilising the individual. Thus, rationalising use of restrictive practices on the basis of challenging behaviour is discriminatory.
- 5.7. Moreover, ‘challenging behaviour’ is a paradigm that individualises, pathologises and neutralises disabled people’s legitimate responses to their living arrangements and experiences of oppression, structural discrimination and violence. In relation to women and girls with disability this behaviour is actually legitimate responses to their living arrangements and their life circumstance and histories:
- Legitimate responses of loneliness, boredom, hurt, frustration and anger to lack of genuine care and companionship by staff
 - Legitimate responses of loneliness, boredom, hurt, frustration and anger to lack of meaningful activities and purpose in their living arrangements and daily routines
 - Legitimate responses of distress, fear and anger to perpetration of violence, abuse and neglect by staff
 - Legitimate responses of distress, sadness, grief and anger to preventing familial, intimate and social relationships
 - Legitimate responses of distress and discomfort in response to failure to recognise and seek assistance for pain or medical conditions
 - Legitimate responses of resistance to their living conditions.
- 5.8. Second, in practice, under the guise of ‘behaviour’ restrictive practices are used in accommodation settings on women and girls with disability for mundane organisational reasons. Rather than being caused by the individual attributes of women and girls with disability or arising as emergency and extreme circumstances, they are instead factored into how services operate and are financially sustainable and profitable. In this way, restrictive practices are used with regularity and banality that can make them difficult to isolate as specific phenomena in the everyday delivery of services:
- Organisational convenience, such as use of menstrual suppression to avoid staff discomfort from having to deal with menstrual blood, and use of contraception or sterilisation to avoid having to support a woman or girl to understand reproduction and sexuality.
 - Organisational efficiency, such as use of menstrual suppression to reduce the labour needed for a specific individual to provide personal care assistance, use of psychotropic medication to quell anger and distress associated with pain rather than have to arrange medical appointments and accompany the individual to those appointments, or denial of support for intimate relationships to avoid the additional labour and time involved in having to assist an individual with navigating the emotional aspects of relationships and transport them to spend time with their partner.

- Organisational legitimisation, such as to quell resistance to staff authority or enforced living arrangements, including the continued use of male support workers or other circumstances that trigger past traumatic experiences for women and girls with disability.
- Organisational risk management, such as non-consensual or coerced contraception to avoid the risk of pregnancy including from sexual assault or from unsafe sex which women are exposed to due to the service's failure to provide support for safe and positive sexual activity, or even use of psychotropic medication to manage distress related to sexual assault perpetrated at the accommodation.
- Organisational profit or financial gain, by reason of the effects of organisational convenience, efficiency, legitimisation and risk management.

- 5.9. The systemic integration of the use of restrictive practices into everyday service delivery might mean they are more difficult to comprehend as violent because their use is not driven by raging hatred, evil or even the intention to cause injury (i.e., the typical perpetrator motivations we associate with criminal violence). However, it is important to note that while the rationales driving use of restrictive practices in everyday service delivery (e.g., protection / risk management, convenience, and efficiency) might seem more benign, these rationales are underpinned by assumptions about the necessity of coercive control, and the violability and un-grievability of people with disability. Thus, while the prima facie intention for using restrictive practices in service contexts might seem harmless or benevolent, these intentions are only comprehensible in a cultural context that devalues and dehumanises people with disability.
- 5.10. Restrictive practices, particularly the gendered forms they take in relation to women and girls with disability, are often understood as positive and supportive in contrast to the historical backdrop of eugenics which was characterised by legislated segregation and restrictive practices of mass populations (e.g. sterilisation and institutionalisation discussed in *Buck v Bell*). However, it is vital to consider eugenics not as a historical, timebound period but rather as a logic that persists.¹⁷⁸ It is vital for the Royal Commission to consider both historical and contemporary injustices of eugenics logic in relation to restrictive practices, and how they intersect with economic drivers associated with warehousing and neglecting people with disability in group homes and other institutional settings.
- 5.11. Moreover, disability services might rationalise use of restrictive practices through drawing on human rights discourse, such as that their use is necessary to realise inclusion, participation, choice and safety, and this is supported by the regulation of restrictive practices in the NDIS which is framed as being about choice, control and human rights for people with disability.¹⁷⁹ There are three concerns with drawing on human rights to justify restrictive practices. First, as we discuss in Section 7, restrictive practices violate human rights. Second, restrictive practices are never the only possible way to achieve inclusion, participation, choice and safety for an individual –these goals can be achieved in innumerable other (potentially more expensive and labour-intensive) ways and restrictive practices further hinder these goals. Third, limitations imposed on individuals in the present through restrictive practices are framed as necessary in order to facilitate longer-term, future inclusion, participation and autonomy. This gives rise to a seemingly perverse justification – that violence against people with disability is necessary now to achieve future enjoyment of positive ideals and rights which are fundamentally at odds with the current violence.
- 5.12. Use of restrictive practices can exacerbate psychosocial disability and trauma in women and girls with disability, in a context where women and girls' psychosocial disability

and trauma might already be associated with previous experiences of violence. There is ‘the potential for the use of restraint to re-traumatise women who have previously been subject to violence or abuse because it reproduces earlier experiences, and/or the feelings associated with them.’¹⁸⁰ Moreover, ‘[e]xperiences of powerlessness and trauma can be exacerbated by gendered power asymmetries’ where men are involved in restraint, and restraint involves removal of clothing.¹⁸¹ Additional to the use of restrictive practices, institutional settings where restrictive practices take place are themselves sites of gender-based violence such as sexual assault.¹⁸² Restrictive practices can have multiple roles in this violence, including its facilitation (e.g. detaining or immobilising a victim) or concealment (e.g. preventing pregnancy, medicating distress). Maker observes that Australian ‘[p]olicies and guidelines indicate little recognition of the implications of restraint use for women, including feelings of pain, fear and powerlessness and retraumatisation’.¹⁸³

- 5.13. Often restrictive practices are used in segregated settings. Segregation ultimately has its roots in harmful social beliefs about the inferiority of people with disability, and their ‘otherness.’¹⁸⁴ Deeply ingrained beliefs that people with disability are not capable of making their own decisions about their bodies, relationships and lives is a justification for substitute decision-making. Segregation and isolation, as well as the loss of liberty and security, personal choice, autonomy and freedom of movement are ‘defining elements’ of institutionalisation.¹⁸⁵ These elements can occur in family homes, large-scale institutions, disability-supported accommodation arrangements, group homes and other residential facilities. They can also occur in segregated employment settings such as Australian Disability Enterprises (sheltered workshops). There is significant evidence that clearly demonstrates these defining elements of institutionalisation are inherent to segregated employment settings, and that they underlie, and often give rise to, the conditions which enable violence, abuse, neglect and exploitation to occur.¹⁸⁶ The sheltered and/or ‘hidden’ nature of segregated and closed settings, combined with a lack of independent oversight, means it is difficult for women with disability to speak up about violence, harassment, abuse and/or exploitation in these settings, make a complaint, or seek information or assistance.
- 5.14. When engaging with disability services about restrictive practices, such as at Public Hearings, it is vital that the Royal Commission does not take at face value services’ rationales for use of restrictive practices but instead engages in deeper exploration in order to draw out the organisational and financial drivers for using restrictive practices on women and girls with disability and the gendered and abled norms that inform these drivers.
- 5.15. It is on the basis of these violent, harmful and discriminatory uses of restrictive practices that WWDA requests the Royal Commission recommend the complete end to the use of restrictive practices in relation to women and girls with disability, including non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion. Such an approach recognises these practices violate various human rights, including those in the CRPD and CEDAW and reflects recommendations made to Australia by the UN CRPD Committee. A gender-neutral approach that focuses on restrictive practices in more general terms will overlook these gendered restrictive practices, and this is already evident in the Restrictive Practices Issues Paper¹⁸⁷ which fails to mention and consider non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion.

A Preliminary Note on ‘Alternatives’ to Restrictive Practices

- 5.16. The Restrictive Practices Issues Paper indicates the Royal Commission is interested in ‘alternatives’ to use of restrictive practices. In contrast, the term ‘prohibit’ is not used in the issues paper.
- 5.17. WWDA understands that evidence-based and costed alternatives are appealing to governments. But, for a Royal Commission that has committed to transformative outcomes, a focus on alternatives is misguided and counter-productive and it would instead be more constructive for the Royal Commission to critically reflect on the ideas underpinning reliance on the paradigm of ‘alternatives’ in the context of violence prevention.
- 5.18. The Royal Commission’s recommendations on restrictive practices should not be contingent on the identification of ‘alternatives’ to restrictive practices. If restrictive practices are understood as violent and harmful, then their use should be prohibited and redressed for this reason. Prohibition and redress should not depend on the availability of ‘alternatives’ (narrowly construed), let alone ‘evidence-based’ alternatives. Such alternatives are unlikely to exist not because they are impossible to conceive but because use of restrictive practices is so widespread and grounded in culturally accepted understandings of people with disability as inherently violable, risky, dangerous, in need of protection, such that there is no impetus to imagine, develop and use such alternatives. Centring ‘alternatives’ in the exploration of restrictive practices risks a situation of the indefinite deferral of ending the violence of restrictive practices as we search of alternatives that simply do not exist, what Voronka refers to as the ‘slow violence’ of evidence-based research.¹⁸⁸ WWDA does not know of any other situation – ranging from the intimate situation of domestic violence, to the widescale situation of genocide – where violence prevention is dependent on alternatives to that violence.
- 5.19. One’s understanding of ‘alternatives’ to restrictive practices is very much contingent on the rationales for using restrictive practices. For example, if restrictive practices are conventionally understood as simply being used in extreme circumstances in response to an individual’s challenging behaviour (as some kind of scientifically objective phenomenon about the inherent behaviour of people with disability), then ‘alternatives’ will be limited to those options that focus on the individual and will involve other ways of limiting an individual’s movement or behaviour. In this way, the very construction of the problem that the use of restrictive practices addresses as one residing in the individual logically leads to the inevitability of coercive interventions in those individuals.
- 5.20. In contrast, if restrictive practices are understood as being used for reasons of organisational convenience, efficiency, legitimation and risk management and as associated with gendered and abled norms (as discussed earlier in this section), then ‘alternatives’ can be understood much more broadly as those that disrupt and dismantle the social, political and economic drivers for grounding disability service provision in profit and finance, and disrupt and dismantle the gendered and abled hierarchies that shape how female embodied experiences are devalued in the context of such service provision. This broader approach to ‘alternatives’ aligns with a critical disability approach to ‘abolition’ of incarceration as not simply being about ending an existing practice but as transforming the economic, political and cultural arrangements that make incarceration a necessary and legitimate part of how we respond to marginalised, racialised and disabled populations.¹⁸⁹
- 5.21. With this broadened understanding of the use of restrictive practices, we now turn to explain how the use of restrictive practices constitutes gendered ableist violence against women and girls with disability.

Interpersonal Violence

- 5.22. On one level, use of restrictive practices constitutes a form of interpersonal violence against women and girls with disability because restrictive practices are non-consensual and coercive interventions perpetrated by an individual (such as a disability support worker) onto another individual that cause harm to those subjected to them (such as physical injury, psychological injury, ongoing trauma, and long-term health effects discussed in Section 4).
- 5.23. However, this approach to violence individualises and decontextualizes restrictive practices. While we agree that restrictive practices do involve interpersonal violence, we see this as only one aspect of their violence. In this section and Section 6 WWDA approaches the violence of restrictive practices in more complex and structural terms and as having more far-reaching social and political impacts on those subjected to them and women and girls with disability more generally.

Ableism

- 5.24. Our starting point for approaching the use of restrictive practices in relation to women and girls with disability as gendered ableist violence is to draw out the ableism underpinning their use.
- 5.25. The first step in our conceptual approach to restrictive practices against women and girls with disability is to challenge the medical model of disability. Disability is conventionally understood through a medical lens, or ‘medical model’, as an individual, natural deviation from ‘a biomedical norm.’¹⁹⁰ This is exemplified by diagnostic approaches to disability that break down a specific disability to particular characteristics residing in the individual, which await discovery through the expert process of diagnosis.¹⁹¹ The medical model views disability as a ‘deficit’ within the individual, a deviation from bodily, cognitive and mental norms, which requires medical, rehabilitation, psychology and educational interventions to diagnose, treat or cure the individual.¹⁹² In this medical approach, people with disability are understood at a biomedical level as less than full humans, and as fundamentally different to people without disability. Disability is something undesirable and a burden on carers and society. Disability evokes (at best) pity and (at worst) disgust and contempt. Collective efforts should be directed towards curing and rehabilitating individuals so they can try to live something approximating a non-disabled life.
- 5.26. The medical model is evident in relation to restrictive practices in a number of ways. One way is that use of restrictive practices is justified on the basis of individuals’ ‘challenging behaviour’ or ‘behaviours of concern’ – these concepts individualise and pathologise behaviour, decontextualize individuals from their circumstances (e.g. violent or neglectful service provision) and their life histories (e.g. trauma), and ignore the power relations in service contexts. As Steele notes:

Some critical disability scholars have problematised the concept of ‘challenging behaviour’ on the basis that it pathologises individuals’ resistance to authority and abuse and shifts attention away from systemic consideration of the problems, illegitimacy, violence, failures and, indeed, existence of institutions. Moreover, Beaupert has shown the racialisation of challenging behaviour, which is but one example of a long history of resistance to settler colonial and racial violence being subverted into pathology. In contrast to these critical approaches, ... through the prism of challenging behaviour, it is not

*merely the individual's behaviour that needs to be addressed but, rather, the entire individual. As Nunkoosing and Haydon-Laurelut state: "The person with intellectual disability and challenging behaviour does not just have troubles; he or she is seen as trouble." Challenging behaviour is generative of far-reaching control.*¹⁹³

5.27. A second way the medical model is evident in restrictive practices is through the kinds of interventions that are involved with respect to peoples' bodies and lives. They involve interventions in individuals' bodies (drugging them, locking them up, sterilising them) rather than addressing the broader environments or relationships in which they are situated, or broader structural conditions.

5.28. Disability activists and critical disability scholars have re-framed the deficit approach to disability in the medical model as 'ableism.' Ableism centres on understandings of fitness that create hierarchies of who is recognised as full humans and citizens and thus most deserving of life and entitled to access to property, resources, and legal protections to sustain life and flourish.¹⁹⁴ Writing about the concept of 'ableism', the Special Rapporteur on the Rights of Persons with Disabilities (Special Rapporteur on Disabilities) has stated that:

*The hegemony of ableism in society has perpetuated the idea that living with a disability is a life not worth living. There is a deep-rooted belief, carved with fear, stigma and ignorance, that persons with disabilities cannot enjoy a fulfilling life, that their lives are incomplete and unfortunate, and that they cannot attain a good quality of life. ... Notwithstanding all the progress achieved over recent decades concerning the rights of persons with disabilities, embracing disability as a positive aspect of humanity remains the final frontier to be conquered.*¹⁹⁵

5.29. Instead of understanding the negative treatment of people with disability as wholly attributable to stigma, discomfort or even hatred towards their perceived deficits, ableism situates the negative treatment of disability in a productive relationship to the positive status of able, white populations. As activist Kira Page explains, ableism 'grants credibility and true humanity exclusively to able bodied people and as such plays a central role in determining which individuals or communities are deemed the useless eaters, the dangerous, the unfit, or the disposable.'¹⁹⁶

5.30. Ableism is not only about disability as an isolated sociological identity category somehow distinct to gender, class, race, sexuality etc. Rather, the status and treatment of people with disability as mediated by the core concept of 'fitness' (which also mediates oppression of other marginalised populations such as Indigenous, poor, racialised) means ableism is part of a bigger picture of interlocking oppression. Ableism is 'a mechanism of white supremacy, capitalism and colonization by devaluing disabled bodies and minds as unnatural, invalid and unworthy across the lines of race, gender, poverty and citizenship.'¹⁹⁷ This also means ableism not only impacts people labelled as disabled, but other marginalised populations.¹⁹⁸ Ableism is central to settler colonial and racist privileging of white access to property, resources, and legal protections, and to neoliberalism which imposes responsibility on individuals for their own economic wellbeing and physical survival, while simultaneously maximising profit from the bodies of those least able to meet this ideal. Ableism is also central to logics of eugenics that positions sick, disabled, racialised and poor populations as a drain on the survival and prosperity of the (white, settler) nation. Indeed, a

consideration of the eugenics era highlights how knowledge about and attitudes towards marginalised populations, which are today seen as quite distinct from each other (e.g. disabled, racialised, poor), were interrelated insofar as they were all positioned as burdens on settler colonial nation-building.¹⁹⁹

- 5.31. Ableism is central to understanding violence against people with disability.²⁰⁰ This is because rather than simply understanding violence as being about stigma, hatred, ambivalence or any other negative feeling towards people with disability, violence is instead interrelated to the abjection of disability as part of a larger project of maintaining ability, gender, sexuality, racial, class and other hierarchies within the settler colonial nation. Thus, focusing only on improving attitudes to people with disability or enhancing their inclusion and participation in society (noting this is a concern of the Royal Commission)²⁰¹ will not address the cultural and structural dynamics of violence, as such approaches that leave untouched the productive dynamic of ableism as constituting fitness and full humanness for a privileged minority. Nor will such a focus dismantle the epistemic authority held by medical and legal disciplines that sustain 'objective' ableist knowledge about disability.
- 5.32. The influence of ableism is poorly recognised in Australia, with the medical model of disability still evident in Australian law, policy and practice. While there has been greater recognition of the rights of people with disability, which has led to associated reforms, the endurance of the medical model and its underlying ableism is still evident in continued reluctance within this reform agenda to comprehensively dismantle 'special' laws, policies, programs and arrangements that segregate, congregate and marginalise people with disability, and enable the use of restrictive practices. Contesting ableism must involve connecting disability discrimination, segregation and violence to challenging liberal settler colonial legal constructions of capacity, reasonableness and fitness, dismantling interlocking systems of oppression experienced by a variety of marginalised populations, unseating privilege and redistributing resources and power that others enjoy through this abjection and oppression.
- 5.33. Understanding restrictive practices through the prism of ableism illuminates three key issues. First, the concepts of 'challenging behaviour' or 'behaviours of concern' do not merely justify restrictive practices – they actually justify longer term and structural inequality and violence in a number of ways. These concepts contribute to the construction of people with disability as inherently violable, risky, dangerous, in need of protection and thus legitimating ongoing control (and as we noted earlier it is not clear that the Royal Commission's search for alternatives explicitly works outside this construction). In subverting disabled people's resistance into the necessity for further submission to control and violence, these behavioural concepts vindicate the authority of services. They can also justify racial and class inequalities, to the extent they are premised on white normative ideals of behaviour, and pathologise resistance to trauma related to racism and colonisation. We note that there is a dearth of data and research on the use of restrictive practices in relation to First Nations people with disability.
- 5.34. Restrictive practices contribute to segregation and ultimately dehumanisation of women and girls with disability, including through confining them in segregated and closed places, and also by denying them many of the embodied and social experiences that characterise what it means to be a woman and human – intimate and loving relationships, articulating our thoughts and wishes, experiencing sexual pleasure, experiencing the relationship between parent and child, and other specific experiences marked as normative for females, such as menstruation, reproduction and mothering.²⁰²

- 5.35. Ending use of restrictive practices is interrelated with ending segregated and closed settings for people with disability because these settings form an intrinsic dynamic of restrictive practices as:
- (a) they are often (though not always) the settings in which restrictive practices are used;
 - (b) the use of restrictive practices in these settings on a structural level sustains segregation and discrimination, and on an individual level sustains isolation, segregation and detention which enables further violence, abuse, neglect, and exploitation against people with disability to flourish; and
 - (c) the use of restrictive practices can have the effect of making places in the general community (such as a family home or group home which is otherwise unlocked to other residents) into segregated and closed settings.
- 5.36. Ultimately, by drawing on ableism we can explore how restrictive practices are both justified by, and themselves produce, dehumanisation and violability, and vindicate hierarchies of privilege, authority and wealth.

Gendering Ableism

- 5.37. Use of restrictive practices in relation to women and girls with disability gives rise to violence at the intersections of abled and gendered norms. Use of restrictive practices exposes women and girls with disability to violence that is justified on the basis of the profound devaluing of embodied and social experiences that are gendered as female – such as menstruation, sexual assault and domestic violence victimisation, female sexual pleasure and intimacy, reproduction, mothering, menopause, and gynaecological cancers.
- 5.38. Restrictive practices in relation to women and girls with disability can be approached as enforcing social norms ascribed to human-ness and to femaleness.²⁰³ As Garland-Thomson states:

Disabled women are, of course, a marked and excluded – albeit quite varied – group within the larger social class of women. The relative privileges of normative femininity are often denied to disabled women. Cultural stereotypes imagine disabled women as asexual, unfit to reproduce, overly dependent, unattractive – as generally removed from the sphere of true womanhood and feminine beauty.²⁰⁴

- 5.39. This is most evident in relation to the restrictive practices of sterilisation, menstrual suppression and contraception, as explained by Steele and Goldblatt regarding the gendered norms of menstruation:

In a context where women are constructed as deficient vis-a-vis men, ... women and girls with disabilities are positioned against norms of the able woman thus giving rise to greater degrees and different forms of discrimination, violence, and marginalization. Women and girls with disabilities are viewed as mentally and physically incapable of meeting gendered norms to conceal their menstruation and to control their sexuality and manage their fertility. Moreover, in being unable to meet gendered norms of motherhood and sexuality, women and girls with disabilities are viewed as burdens on those who provide care to

*them, with menstruation being seen as an additional and superfluous demand on labour and time for carers because women and girls with disabilities are viewed as not needing menstruation for reproductive reasons. As such, there are assumptions operating on at least three levels: (a) that women and girls with disabilities should conceal and control their menstruation; (b) that women and girls with disabilities are incapable of doing so; and (c) that it is inefficient and unnecessary for others to support women and girls with disabilities to menstruate.*²⁰⁵

- 5.40. However, by reason of their diversity, not all women and girls with disability will be equally positioned in relation to norms of femininity (notably because these norms are not only informed by ability but whiteness, class and heterosexuality etc). Therefore, some women and girls with disability who are deemed to diverge further from these norms might be more targeted for restrictive practices. Moreover, Nirmala Erevelles argues for the necessity of attention to the ‘actual historical, social, and economic conditions that influence (disabled) people’s lives, conditions further mediated by race, ethnic, gender, class and sexual politics.’²⁰⁶ Thus, as well as abstract gendered norms, it is vital to consider how the differing material economic and social conditions of women and girls with disability (in a contemporary and historical context) inform their unequal exposure to restrictive practices.
- 5.41. To this end, it is also useful to draw on the analytical tool of intersectionality. As Patricia Hill Collins and Sirma Bilge explain: ‘[a]s an analytic tool, intersectionality views categories of race, class, gender, sexuality, class, nation, ability, ethnicity, and age – among others – as interrelated and mutually shaping one another’ and ‘while often invisible, these intersecting power relations affect all aspects of the social world.’²⁰⁷ Intersectionality involves nuanced analysis of power relations ‘both via specific intersections – for example, of racism and sexism, or capitalism and heterosexism – as well as across domains of power – namely, structural, disciplinary, cultural, and interpersonal’²⁰⁸ and directs attention to ‘the importance of examining intersecting power relations in a social context’, such as settler colonialism.²⁰⁹ A further aspect is relationality, which ‘embraces a both/and analytical framework that shifts focus from seeing categories as oppositional, for example, the differences between race and gender, to examining their interconnections.’²¹⁰
- 5.42. For present purposes, intersectional analysis of the use of restrictive practices on women and girls with disability is particularly useful in three ways. First, it focuses on women and girls’ exposure to and experiences of restrictive practices in the context of relationships between ableism and other systems of oppression such as sexism, racism and classism. Women and girls with disability who fit normative ideals of the responsible disabled subject who is trying to overcome their disability and contribute to society (or at least not using so much public resources) might be less exposed to restrictive practices. In contrast, others (e.g. who are criminalised, poor, drug users, racialised or Indigenous) might be more exposed to restrictive practices because they are seen as having ‘transgressive’ or ‘non-normative’ forms of disability²¹¹ ‘that do not fit into the neat packages of a highly mobile, young, wheelchair user working to be independently productive, are easily dismissed as not truly deserving of benefits or accommodations.’²¹² Judgements about ‘challenging behaviour’ and ‘behaviours of concern’, and economic efficiency in care, will be informed by an individual’s disability, as well as whether their disability is meeting normative expectations of disability and how much their care, wellbeing and lives are worth as against the care, wellbeing and lives of other individuals with disability and maximising profit and financial sustainability of services. Intersectionality situates these judgements

in the specific social and historical contexts of Australia, including eugenics, settler colonialism and neoliberalism and thus invites a finer level of discrimination in determining the relative significance of care, wellbeing and lives of different categories in the disability community, such as First Nations, racialised and poor women and girls with disability. This was noted by Uncle Lester Bostock in the context of ‘double disadvantage’²¹³ and in Scott Avery’s work on intersectionality and First Nations people with disability.²¹⁴

- 5.43. Second, given the particular focus in settler colonialism and eugenics on the role of women’s reproduction to the fitness of the nation, intersectionality focuses our attention on the particular concern with women’s sexuality and reproduction in restrictive practices related to women and girls with disability (e.g. sterilisation, contraception forced child removal). The use of restrictive practices on women and girls with disability, particularly sterilisation and contraception, is often understood against a historical backdrop of eugenics (e.g. sterilisation and *Buck v Bell*), with the modern, individualised legal regulatory approach favourably contrasted to mass legislative historical approach. However, it is vital to consider eugenics not as a historical, timebound period but rather as a logic that persists in contemporary restrictive practices.²¹⁵ For example, sterilisation and contraception of women and girls with disability, abortion and forced removal of children from women with disability reflect assumptions that women and girls with disability should not be sexually active or reproduce because they will be unfit parents and intervention is necessary to protect any children that are born and society at large from the purported intergenerational biological or social transference of their disability. A further example is trivialising or punishing the pain experienced by women and girls with disability, where instead of accessing medical advice and treatment for physical pain or trauma, women and girls with disability are subjected to interventions that approaches their expressions of distress and discomfort as an organisational inconvenience and problem to control. The incomprehensibility of women and girls with disability experiencing pain speaks to their dehumanisation and the devaluing of their bodies and lives.
- 5.44. Third, intersectionality highlights how prohibiting and redressing the violence of restrictive practices against women and girls with disability requires broader structural change.
- 5.45. As well as considering interlocking oppression in relation to restrictive practices and the experiences of women and girls with disability, it is also important to consider how oppression shapes disablement itself, including the role of state violence, racism, and poverty in making some women and girls more likely to become disabled (including through restrictive practices) and/or more likely to be exposed to restrictive practices. Erevelles points out the need to reject sentimentalising or universalising disablement:

How can acquiring a disability be celebrated as “the most universal of human conditions” if it is acquired under the oppressive conditions of poverty, economic exploitation, police brutality, neo-colonial violence, and lack of access to adequate health care and education? What happens when human variation (e.g. race) is deployed in the construction of disabled identities for purely oppressive purposes (e.g. slavery colonialism, and immigration law)?²¹⁶

Thus, the Royal Commission might situate its exploration of the inequalities of exposure to restrictive practices (and other forms of violence) in the broader context of the inequalities of disablement.

- 5.46. In the following sub-sections, we introduce dynamics of violence that deepen an understanding of restrictive practices as gendered ableist violence.

Dehumanisation: Ontological and Epistemic Violence

- 5.47. Use of restrictive practices denies women and girls with disability the capacity to control their bodies and define their experiences (epistemology) and ultimately negates their value in the world (ontology). Ontological and epistemic violence are further dimensions of the gendered ableist violence arising from use of restrictive practices on women and girls with disability.
- 5.48. Ontological violence relates to how disability as a way of being in the world renders individuals as deserving of violence and incomprehensible as grievable victims. Kafer argues that this ontology of disability relates to temporal relations between disability and futurity. Conventionally, the envisioning of a desirable future is one without disability and the negation of the legitimate existence of disabled people.²¹⁷ This is most evident in medical initiatives such as genetic testing for disability, utilising assisted reproductive technologies to avoid disabled babies, and a focus on developing medical cures for disability. It is also reflected in education, recreational and employment initiatives that make social, economic and political inclusion of people with disability conditional on their approximation of normative expectations of behaviour and appearance. The illegitimacy of disabled peoples' ways of being in the world as disabled position them as less than full humans now and in the future, contributing to an understanding of violence as necessary to expel disability from humanity.²¹⁸ In turn, people with disability are not 'grievable' in their injury or deaths – as less than humans, their suffering and death is not recognised as a social loss.²¹⁹ Ontological violence is also apparent in relation to other marginalised groups such as racialised people²²⁰ and First Nations and Indigenous people.²²¹
- 5.49. Ontological violence is gendered, insofar as what counts for recognition as a legitimate existence is not only about normative understandings of what it means to be (a full/valued/normal/inviolable/grievable) human and but also normative understandings of what it means to be (a full/valued/normal/inviolable/grievable) female, and thus legitimate subjects (or perhaps, in some instances of extreme dehumanisation, objects) of violence.
- 5.50. 'Epistemic violence' is a further and closely related dynamic of violence. Epistemic violence can be understood by reference to Miranda Fricker's work on 'epistemic injustice.' Fricker explains epistemic injustice as 'a wrong done to someone specifically in their capacity as a knower.'²²² She identifies two specific forms of epistemic injustice: testimonial injustice and hermeneutical injustice. She explains:
- Testimonial injustice occurs when prejudice causes a hearer to give a deflated level of credibility to a speaker's word; hermeneutical injustice occurs at a prior stage, when a gap in collective interpretive resources puts someone at an unfair disadvantage when it comes to making sense of their social experiences. An example of the first might be that the police do not believe you because you are black; an example of the second might be that you suffer sexual harassment in a culture that still lacks that critical concept. We might say that testimonial injustice is caused by prejudice in the economy of credibility; and that hermeneutical injustice is caused by structural prejudice in the economy.²²³*
- 5.51. Epistemic violence in relation to people with disability is apparent in: the overriding of their consent and the failure to recognise their capacity to make their own decisions and choices; the pathologising of their expression, resistance and distress; and the absence of social, political and legal paradigms to recognise the full spectrum of their experiences of injustice and violence.²²⁴ In relation to restrictive practices, testimonial injustice is evident

in: the denial of legal capacity in the use of restrictive practices; and the law and justice system practices which deny people with disability the opportunity to be recognised as victims and witnesses if they were to seek justice for restrictive practices. Hermeneutical injustice is evident in the exclusion of restrictive practices from legal and political paradigms of violence, and in the normalisation of violence and control in closed and segregated settings. This makes it difficult for individuals to identify restrictive practices as exceptions to the everyday, and as acts of violence.

- 5.52. Epistemic violence is supported by medical knowledge which renders individuals legible and knowable by singular reference to diagnosis. As Chapman and Withers note: '[c]lassifying a person or an imagined type of person as thoroughly knowable is always violent. It involves subtracting purpose, responsibility, agency, or animacy from framings of how that person or "those people" function.'²²⁵ It is also apparent in foundational legal concepts such as 'capacity', as well as substituted decision-making laws and legal processes that prevent individuals from having their choices and views legally recognised. It is apparent in the actions of service providers in denying people with disability choices in even the smallest and perhaps seemingly mundane aspects of their lives, such as social interactions, sleeping patterns, and eating.²²⁶
- 5.53. Epistemic violence in relation to people with disability is situated in interlocking systems and forces of oppression. For example, resistance expressed by racialised women and girls with disability might be more readily understood as dangerous and in need of suppression through restrictive practices.²²⁷ Resistance to patriarchy expressed by women and girls or the failure of women and girls to follow social norms might be pathologised as challenging behaviour in need of restrictive practices.²²⁸ Expression related to sexuality and menstruation might elicit a more repressive response through non-consensual and coercive sterilisation and menstrual suppression in relation to women and girls with disability in order to enforce gendered norms of the concealment of signs of menstrual blood and emotions associated with menstruation.²²⁹ Moreover, women and girls with disability are less likely to be believed when they report violence. This is evident in the context of RACFs. Women in RACFs experience sexual violence, including from staff and other residents.²³⁰ Research indicates victims predominantly have disability.²³¹ Research suggests this is particularly problematic for older women with dementia, because their disability means they are less likely to be believed or understood when they disclose sexual assault and police are unlikely to pursue the matters. Moreover, their distress might be perceived as a behavioural symptom of their dementia and thus responded to through the use of restrictive practices.²³² The impacts are particularly dire, as noted by Smith in their systematic review of literature on sexual assault of older people in nursing homes: '[w]ithin a year of being assaulted, 50% of victims died ... Considering older people have an increased risk of mortality after traumatic experiences or of suffering from anxiety disorders, it is reasonable to postulate, the sexual assault can contribute to an accelerated death.'²³³
- 5.54. Restrictive practices perpetrate longer term epistemic violence through limiting future opportunities for self-understanding and expression. As explained by Roper et al (all of whom have lived experience of the Australian or New Zealand mental health systems) in the context of mental health systems, restrictive practices and the broader mental health system have: 'oppressive, ongoing and cumulative negative impacts on self-hood from restraints on meaning-making, self-expression, hope and trust in oneself.'²³⁴ They state: '[t]o be able to think freely is surely the most sacrosanct of all freedoms, and to interfere with this without a person's consent is both ethically and physically harmful.'²³⁵

- 5.55. Engaging with the epistemic violence of the use of restrictive practices directs the Royal Commission's attention to how people with disability are impacted by the negation of epistemic and ontological authority. This not only negatively impacts people with disability, but has a productive and positive impact on others by validating and empowering the authority of legal, medical and helping professionals.²³⁶ Yet rarely is this authority challenged because these professions occupy epistemically and economically privileged positions in society.
- 5.56. Therefore, considering ontological violence and epistemic violence in the use of restrictive practices can help the Royal Commission to understand the violence of restrictive practices in several inter-related ways. First, restrictive practices as coercive interventions deny individuals the opportunity to make their own choices about their bodies and lives. Second, conventional justifications of restrictive practices as protective responses to individual behaviour deny individuals the opportunity to express their resistance to their circumstances, to express distress in response to previous experiences of violence, or to express themselves in ways that elicit in others discomfort, fear, confusion or disgust. Fourth, we can move beyond an individualised understanding of attitudes towards disability in order to understand an entire cultural logic about disability that shapes the parameters in which people with disability can be known and can exist in the world. This broader understanding is informed by ableism, imperialism, colonialism, capitalism, patriarchal heteronormativity and white supremacy. In turn, we can shift from focusing on changing individual attitudes (e.g. through community education) to exposing and transforming cultural logics about the violability, ungrievability and need to control people with disability embedded in invisible/mundane/everyday aspects of society, such as the built environment, service provision, bureaucratic processes, funding arrangements, regulatory frameworks, and in the knowledge systems underpinning some of the most epistemically and financially privileged professions in society. Exposing and transforming cultural logics includes interrogating the endurance of eugenics logic about disability (and other marginalised populations) in legal and medical knowledge and disability services systems. A focus on cultural logics also indicates the fundamental interconnection between preventing and redressing violence against people with disability and preventing and redressing material and epistemic/ontological violence against other marginalised groups.

Settler Colonial Violence

- 5.57. Research suggests that First Nations people are more subject to restrictive practices,²³⁷ and this can be understood in a broader context of their higher representation in systems of incarceration and control, such as criminal justice and child welfare systems. Restrictive practices are one part of a broader phenomenon of settler colonial violence.
- 5.58. Settler colonial violence is not simply about prejudice or hatred towards First Nations people. Rather, it is about a 'logic of elimination' – the dispossession, displacement and elimination of First Nations people.²³⁸ Bond explains that settler colonial violence gives rise to the deliberate irrelevance of First Nations people's lives and deaths:

And there really is nothing mysterious about the deaths of Aboriginal people in Australia, either.

The settlers have long insisted that our death was destined, that our race was doomed, and that we, as a people, were vanishing. Our disappearance was inevitable because it was necessary to sustain terra nullius, the foundational

*myth of Australia. Black deaths rationalised White invasion and land expansion in Australia.*²³⁹

- 5.59. Moreover, positioning First Nations people as ‘deviant’ or ‘vulnerable’ also involves positioning white people and the settler state as ‘rescuer’, which thus rationalises death and undercuts self-determination, absolving the settler state from accountability:

Black deviance (statistical or otherwise) has been a useful narrative device for the settlers.

*Black deviance supports claims of White benevolence, in which White people are simultaneously positioned as our aspirational goal and saviours. It suggests to us that Black lives matter to them. Yet in emphasising our deviance, the sins of a system that White people uphold and benefit from remains unnamed and unnoticed.*²⁴⁰

- 5.60. Discourses of disability, when applied to First Nations people, can be used to justify the logic of elimination in settler colonial violence.²⁴¹ The development of diagnostic and service frameworks about disability is inextricably related to notions of race, whiteness and Indigeneity, and was used to justify dispossession and violence against Indigenous and First Nations people.²⁴² Scholarship exploring the juncture of disability, eugenics and settler colonial histories has highlighted the interrelationship of Indigenous and racial settler colonial violence with disablement and medical epistemologies of disability,²⁴³ as well as the role of disability diagnosis and disability-specific coercive interventions in rationalising enslavement, dispossession, child removal, disenfranchisement, incarceration, sterilisation and genocide of First Nations people and other racialised minorities.²⁴⁴
- 5.61. Exploring restrictive practices in the context of settler colonial violence is important for understanding the reasons and impacts of their use in relation to First Nations people with disability, as well as for moving beyond a purely individualised approach to supported decision-making and redress of restrictive practices to also recognise First Nations (collective) trauma and self-determination.
- 5.62. The dynamic of settler colonial violence helps to explore how the use of restrictive practices against women and girls with disability, notably the gendered forms related to reproduction, sexuality and parenting, contribute to dispossession, displacement and the elimination of First Nations people. This dynamic is also useful for considering the role of supporting First Nations’ self-determination and nation-building as part of wide-reaching redress and transformative change, additional to prohibition and redress of restrictive practices.

Profiting from Violence: Economic Dynamics of Restrictive Practices

- 5.63. The economic devaluing of the care, wellbeing and lives of women and girls with disability through use of restrictive is not simply a matter of structural discrimination and oppression. There is also a productive element to use of restrictive practices on women and girls with disability – financial enrichment to service providers. As we noted earlier in this section, restrictive practices enhance the wealth of disability service providers who can use restrictive practices to maximise economic efficiency of care provision (this being particularly well-known in the context of RACFs),²⁴⁵ as well as to repress dissent and resistance.

- 5.64. Therefore, we argue that economic violence is a key dynamic of the gendered ableist violence of restrictive practices, which the Royal Commission must engage with in order to understand the drivers for continued use of restrictive practices and what is needed to comprehensively prohibit and redress this violence.
- 5.65. As discussed in the context of ‘ableism’ people with disability are positioned as surplus and a burden on the economy. For women and girls with disability, this can relate to the view that they fail to provide both productive and reproductive labour. By this we mean it is not only the case that women and girls with disability are considered unfit for full, open employment, but they are also unfit for labour in the private family sphere such as reproducing and parenting children and maintaining a household.
- 5.66. The exclusion of women and girls with disability as labour from the economy gives rise to other (violent) ways of extracting profit from their bodies.²⁴⁶ In general terms, this extracting might involve profit derived from their grossly underpaid labour as is evident through Australian Disability Enterprises (sheltered workshops) and historically in their forced/unpaid labour in disability institutions.²⁴⁷ Yet, beyond the conventional understanding of labour as ‘work’, extraction of profit from those deemed unproductive or incapable can occur through the economic gains derived from warehousing people with disability in institutions and group homes and precarious housing such as boarding houses.²⁴⁸ This warehousing involves congregating a large number of people with disability at a higher concentration than would occur in the community which can also be coupled with disability service provision which is driven by organisational convenience and efficiency rather than genuine care. Warehousing maximises organisational profit at the same time that it causes emotional and physical violation and neglect, and in turn physical pain and illness, psychological distress and even premature death of its residents. Restrictive practices are a core aspect of maximising the ‘labour’ of residents in disability and aged care accommodation because they help minimise the cost and resources required to acquit the services for which they are funded.
- 5.67. Economic dynamics of violence can assist in understanding two particular dimensions of the violence of restrictive practices. First, economic violence facilitates a deeper appreciation of the financial drivers of restrictive practices, notably how violence can result in financial benefit to others. The use of restrictive practices can be understood as opening up the possibility of people with disability as presenting economic opportunity and gain to others, rather than simply being seen as an economic burden on others. Restrictive practices are a means of warehousing women and girls with disability, not simply to repress them and keep them ‘out of sight, out of mind’ but to extract maximum profit from their bodies. This is particularly evident in relation to sterilisation, menstrual suppression and contraception as a means of eliminating the need for staff and resources to be used on managing menstrual blood, which is framed as an unnecessary burden on carers, as noted earlier in this section when discussing ‘gendering ableism’.²⁴⁹
- 5.68. Second, considering the financial enrichment associated with use of restrictive practices broadens the possibilities of redress, as extending beyond compensation of injury/loss to the person with disability, to include restitution of financial benefit to perpetrators and services. This will require careful consideration of the scope of financial gain, notably when the economic violence has been historical in nature and charities or corporations have subsequently grown the wealth they derived from the bodies of people with disability, such that there is a continuity of financial benefit across time (even if they have purportedly transformed their ethos and practices). Redress of financial enrichment requires a switch in how economies of disability and aged care service provision are typically understood.

This broadened approach to redress might be relevant to the group homes context that prompted the Royal Commission's commitment to exploring redress in its future work.

5.69. Therefore, considering economic dynamics of violence of restrictive practice is useful in three respects. First, it highlights the financial incentives for perpetrating violence through restrictive practices. Second, it highlights that preventing violence must involve dismantling financial and economic structures that provide profit and financial incentives (e.g. disability service and aged care provision as profitable or a lucrative investment). Third, it indicates that redressing this violence must not only attend to remedies for the injuries experienced, but also explore remedies specifically related to accountability for financial enrichment of perpetrators.

Structural Violence

5.70. Women with disability throughout Australia bear a disproportionate burden of poverty and are amongst the poorest of all groups in society. They experience multiple and intersecting forms of discrimination and disadvantage, which creates and perpetuates systemic inequality between disabled men and women. In practice this means that women with disability have far fewer opportunities, lower status and less power and influence than men with disability (and non-disabled women), and far less chance of realising substantive enjoyment of rights. These rights include: freedom to act and to be recognised as autonomous, fully capable adults; to participate fully in economic, social and political development; and to make decisions concerning their circumstances and conditions.²⁵⁰

5.71. The concept of 'structural violence' can help to understand the broader impacts of restrictive practices on inequality, discrimination and disadvantage experienced by women and girls with disability. Structural violence includes how forces of oppression such as ableism, imperialism, colonialism, capitalism, patriarchal heteronormativity and white supremacy shape the differential experiences of violence and flourishing between groups of people with disability (e.g. First Nations people with disability, racialised people with disability, people with disability in the criminal justice system, or people with disability who live in public housing).²⁵¹

5.72. For many women and girls with disability, restrictive practices are not simply a one-off event in a life otherwise free of violence. Rather, these are generally one dimension of violence in lives situated in an entire network of interlocking laws, systems and disciplines that enable violence, oppression, segregation and precarity across their life. The interlocking of laws, the long-term nature of legal orders, and the funding, service and policy pipelines transfer people between segregated contexts and settings during their lives.

5.73. Restrictive practices deny to people with disability wellbeing and flourishing, physical and psychological safety, social, economic and civic participation, experiences of intimacy and opportunities for family formation, and thus contribute to longer term structural violence experienced by people with disability across their lives and across generations, and this structural violence should be understood in a settler colonial context for its particular impacts on First Nations people.

5.74. This is particularly so for women with disability in the criminal justice system. Their experiences of restrictive practices might be in the context of incarceration in prison, community-based forensic disability services or court diversion orders confining them to a group home.²⁵² Their experiences of restrictive practices may also be situated in a

broader context of regular contact with police as persons of interest (as well as victims of crime and under civil mental health legislation) and multiple periods of incarceration over their lives. Many women with disability in the criminal justice system experience significant social disadvantage as adults — such as homelessness, sexual and domestic violence, removal of children, and limited access to disability services — as well as early childhood disadvantage through child abuse and neglect, high rates of out-of-home care (OOHC) and contact with juvenile justice. They might have experienced violence and a lack of accountability from the State, including in the context of services purportedly directed towards helping them (e.g. child welfare, education and health). A high number of women in prison have experienced victimisation and trauma.²⁵³ This can exacerbate the impacts of restrictive practices in prison and also give rise to the possibility that restrictive practices are used to respond to behaviour that relates to those past experiences. For some, these lives of violence, injustice and State irresponsibility are intergenerational or experienced by an entire community. For First Nations people, and women and girls with disability in the criminal justice system, it is one aspect of ongoing settler colonial dispossession and displacement.

- 5.75. Situating use of restrictive practices within broader structural violence shows the extent that it contributes to longer term violation and dehumanisation of people with disability. Further, this positioning provides impetus for wide-reaching redress and transformative change in addition to the prohibition and redress of restrictive practices and also demonstrates the problem of a focus on evidence-based ‘alternatives’ to restrictive practices (narrowly construed), as we discussed earlier in Section 5.
- 5.76. Structural violence might, in part, take the form of ‘slow violence.’ Nixon defines ‘slow violence’ as ‘violence that occurs gradually and out of sight’ and ‘is dispersed across time and space.’²⁵⁴ Slow violence ‘is typically not viewed as violence at all’ by reason of the conventional understanding of violence as ‘an event or action that is immediate in time, explosive and spectacular in space.’²⁵⁵
- 5.77. Drawing out the dynamics of slow violence in relation to use of restrictive practices focuses attention on harms that might otherwise ‘slip under the radar’ because these harms accumulate gradually over time. ‘Slow violence’ is particularly useful in the context of women and girls with disability who are subject to extreme social disadvantage, multiple forms of coercive intervention and confinement, and State irresponsibility across their lives.²⁵⁶
- 5.78. Building on earlier discussion of restrictive practices as gendered ableist violence, we can expand the temporal and structural scale of the harm inherent in the use of restrictive practices to consider how their use contributes to the conditions where individuals with disability, and entire disabled populations deemed of less social value, are cast in a form of existence that denies them opportunities to flourish (or even live). This has been referred to as ‘debilitation’,²⁵⁷ (others have referred to this as biopolitical ‘scientific racism’,²⁵⁸ ‘or ‘slow death’).²⁵⁹ Puar defines ‘debility’ as a process of positioning populations in an ongoing state of precarity through disability — of systemic deprivation and violence, ‘the slow wearing down of populations.’ Puar argues that debilitation does not occur by chance or because of some inherent characteristics of certain populations, but rather is a deliberate practice that causes populations to be positioned in precarious circumstances ‘and maintain[s] them as such.’²⁶⁰ In a similar vein, Berlant defines ‘slow death’ as ‘the physical wearing out of a population and the deterioration of people in that population that is very nearly a defining condition of their experience and historical existence.’²⁶¹ Drawing on concepts of debility and slow death, we can consider how restrictive practices expose women and girls with disability to violence and control that can contribute to their precarity and premature death across their lives.

5.79. Attention to ‘slow violence’ and debility’ might have methodological implications for the Royal Commission’s ‘life course approach’. The Royal Commission might consider exploring:

- entire life courses of particular embodied individuals who have experienced restrictive practices at some stage in their life, in order to understand the cumulative and interrelatedness of circumstances across one’s life as shaping the overall possibilities for violence and flourishing; and
- how different systems’ logics, practices and legal frameworks interlock to hold certain disabled populations in a way of life where violence is natural, even after a particular period of restrictive practice has ceased.

5.80. We now turn to discuss the violence associated with the legality of restrictive practices.



6 LEGALITY OF RESTRICTIVE PRACTICES

6. LEGALITY OF RESTRICTIVE PRACTICES

- 6.1. This section explores the legality of restrictive practices, arguing that, in the context of women and girls with disability, restrictive practices are a form of gendered ableist legal violence.
- 6.2. Rather than simply looking at restrictive practices in relation to their use on the ground, it is important the Royal Commission also explore the legal authorisation and regulation of restrictive practices. Laws on restrictive practices fall into 3 categories:
- Firstly, laws authorising third parties to either use restrictive practices or consent to others using restrictive practices. Examples include:
 - Common law *parens patriae* doctrine that grants to State and Territory Supreme Courts jurisdiction to order use of restrictive practices and appointment of substitute decision-makers to authorise restrictive practices;
 - Guardianship laws that authorise specified tribunals to appoint substituted decision-makers to consent to restrictive practices;²⁶²
 - Mental health laws that authorise involuntary detention in mental health facilities, involuntary mental health treatment in mental health facilities and community treatment orders;²⁶³
 - Family Court’s welfare jurisdiction which authorises parents to consent to sterilisation of their disabled children;²⁶⁴ and
 - Child protection legislation which authorises medical practitioners to carry out emergency medical treatment on children without the consent of parents and guardians.²⁶⁵
 - Secondly, laws excluding some individuals who use restrictive practices from criminal responsibility and civil liability:²⁶⁶
 - Common law doctrine of lawful authority, where restrictive practices used pursuant to statutory or judicial authority (as in the first category of examples);²⁶⁷ and
 - Common law doctrine of necessity, where restrictive practices used in situations of imminent danger.²⁶⁸
 - Thirdly, laws guiding use of restrictive practices in specific service sectors, where failure of a service to comply can result in penalties against the service including loss of accreditation and funding.²⁶⁹ Examples include:
 - Regulation of use of restrictive practices in NDIS funded services;²⁷⁰ and
 - Regulation of use of restrictive practices in Commonwealth funded RACFs.²⁷¹
- 6.3. The Royal Commission has commissioned a very detailed research report by Australian Government Solicitors on laws affecting people with disability which extends to laws relating to restrictive practices.²⁷² However, to date the Royal Commission has not explored legal dynamics of restrictive practices (including some of the laws identified in the Australian Government Solicitors research report) and the role of justice systems in both enabling perpetration of violence through restrictive practices and situating this violence beyond redress.

- 6.4. By reason of their lawfulness, restrictive practices are distinct to many other forms of violence that the Royal Commission is considering, and distinct to conventional understandings of violence that are informed by criminal law notions of consent and intention to harm. In order to fully explore restrictive practices as violence, abuse, neglect and exploitation of women and girls with disability, it is vital the Royal Commission consider key legal/justice and regulatory contexts of restrictive practices.
- 6.5. Restrictive practices constitute non-consensual and coercive interventions on the basis of disability that are permitted by law (i.e. legal doctrine, legal institutions and legal process) and supported by state funded legal professions, justice systems, Government departments and disability, mental health and welfare services. Through law restrictive practices are state-sanctioned and just and thus become framed as non-violent. In being lawful, perpetrators are not held accountable and those subjected to restrictive practices are not entitled to redress. Ultimately, the legality of restrictive practices sustains the violability, ungrievability and need to control women and girls with disability.
- 6.6. To date, the Royal Commission has focused on restrictive practices as they are used ‘on the ground’, for example, in schools and group homes. While this is important, it is only part of the picture. Behind much of this violence are legal frameworks and court and tribunal orders that authorise the enacting of this violence, protect perpetrators from accountability and deny redress to victims/survivors. Overlooking in-depth exploration of legal and justice systems risks the absence of recommendations addressing these systems, and thus any changes to ‘on the ground’ systems focused on changing practice and cultures that give rise to instances of violence will not remove the legal possibility and permissibility for this violence. Therefore, in order to fully explore restrictive practices, the Royal Commission must expand its focus to legal sites – courts, tribunals, legislative drafting offices and law firms.
- 6.7. It is vital the Royal Commission recommend the complete prohibition of restrictive practices. An alternative focus only on ending use (and not ending legality) leaves intact the legal frameworks that render restrictive practices possible and permissible and unrealistically depends on a complete behaviour change by individuals and organisations currently using restrictive practices (in a context where there are profit/financial incentives in the disability and aged care systems to continue using restrictive practices). An alternative focus on ‘reducing’, ‘eliminating’, or ‘minimising’ restrictive practices still enables continued use of restrictive practices on some individuals. Even if there is a reduction in the total number of individuals this does not diminish their impact at an individual level on those who are still subjected to them. Prohibition is consistent with recommendations to Australia from the UN CRPD Committee.²⁷³ In particular, substitute decision-making, compulsory treatment and ‘best interest’ approaches have been thoroughly criticised as fundamentally contravening the CRPD and as intrinsically value laden.²⁷⁴ A supported decision-making approach recognises that legal capacity underpins personhood and is indispensable for the exercise of civil, political, economic, social and cultural rights.
- 6.8. Moreover, the Royal Commission must explore access to justice issues in relation to restrictive practices:
- availability and accessibility of legal information about victims’ compensation and redress under civil and criminal law – particularly in the context of disability, mental health and aged care services, and in segregated and closed settings;
 - availability and accessibility of disability inclusive legal services that can provide legal advice and legal representation for victims of violence related to restrictive practices, including removing substituted decision-making and compulsory treatment orders and obtaining redress;

- impact of Australian Government and State and Territory Government funding on the capacity for legal and advocacy services to engage in fully independent and impartial individual and systemic advocacy in relation to restrictive practices; and
 - accessibility of court and tribunal processes for removing substituted decision-making and compulsory treatment orders, challenging the legality of restrictive practices, holding substitute decision-makers accountable for harm associated with their decision-making (e.g. sexual assault, neglect and malnutrition in a group home that the individual is detained within due to a guardianship decision that they be detained there, failure to access medical and dental care where they have medical decision-making authority), and obtaining redress.
- 6.9. WWDA's separate submission in relation to sexual and reproductive violence will provide further information about the nature, impacts and legal frameworks of sexual and of this section focuses on conceptualising law's role in the violence of restrictive practices.

Legal Violence

- 6.10. Restrictive practices are a form of legal violence by reason of their legality.
- 6.11. As Steele has discussed elsewhere, 'legal violence' is the regulation or permitting (rather than total prohibition) by legal doctrine and legal decision-makers of interventions in individuals' bodies and lives.²⁷⁵ The idea of legal violence has its basis in the notion that all law is inherently violent²⁷⁶ and that physical force is implicated in (rather than external to and in absolute opposition to) law. At the core of the concept of 'legal violence' is a relationship between the 'word' of law (that is, the legal interpretation and the resulting judgment and court order) – and a 'deed' of violence itself (that is, the act of non-legal/ judicial actors administering the order).²⁷⁷ An example offered by US legal scholar Robert Cover is criminal punishment. Criminal punishment in the form of incarceration and loss of liberty can be analysed as legal violence because the punishment meted out by prison officers is done pursuant to the terms of the words of the judge's sentence, and it is because the act of punishment is constrained by the words of this legal order that it is a legitimate use of violence in being fair, humane, just and non-arbitrary.²⁷⁸
- 6.12. The 3 categories of restrictive practice laws mentioned above give rise to legal violence in two key ways.
- 6.13. First, restrictive practices are non-consensual in the sense that an individual with disability is subjected to these interventions irrespective of their consent. Ordinarily, this would amount to criminal or civil assault or false imprisonment – which turn on the absence of consent – and a victim-survivor would be entitled to seek assistance of the criminal justice system and civil remedies for compensation and other forms of redress. However, in the context of restrictive practices criminal offences or civil causes of action will not be made out where a third party is empowered to consent to the restrictive practices or use restrictive practices, or where restrictive practices are used in a context of imminent danger. Even where the restrictive practices are not lawful (e.g., there is no emergency situation or there is no substituted decision-making order in place) such that accountability and redress is technically possible, there might be structural barriers to accessing justice systems which prevent individuals achieving accountability and redress.
- 6.14. Second, use of restrictive practices in specific service sectors is enabled within particular settings (e.g. disability group homes, RACFs). Governments have the power to specify

the kinds of conduct allowed and prohibited in these settings as a condition of funding or accreditation, even if this conduct is otherwise lawful in the community. Therefore, governments could legislate to prohibit restrictive practices specifically in disability and aged care settings. Instead, disability service and aged care laws on funding and accreditation explicitly permit restrictive practices where these have been authorised pursuant to substitute decision-making laws. The NDIS regulatory framework creates two categories of restrictive practices: authorised restrictive practices; and unauthorised restrictive practices. While this might seem positive because restrictive practices need to be authorised, unauthorised restrictive practices are in effect a second (de facto) category of permitted restrictive practices by reason of:

- (a) the sheer number of unauthorised restrictive practices;
- (b) the lack of actions taken in relation to unauthorised restrictive practices; and
- (c) actions (if they do occur) are largely pedagogical/developmental, rarely impact on funding/accreditation of services and do not provide redress to victims.

The RACF framework has a similar problem because legislative reforms directed to addressing the systemic use of restrictive practices (notably chemical and physical restraint) have not prohibited restrictive practices. Instead, they have introduced greater regulation of restrictive practices which simply gives greater legitimacy to this violence. At the same time, the use of restrictive practices is so pervasive in aged care that it is unclear if regulation is even limiting these practices, let alone providing access to redress for victims.

- 6.15. Moreover, even where restrictive practices are not lawful (e.g., there is no substituted decision making order in place or there is no emergency situation to otherwise excuse the intervention pursuant to the doctrine of necessity), there might not be any legal ramifications for the service providers because of access to justice barriers mentioned above which prevent complaints being made, inactive regulatory bodies and systemic cultures of using restrictive practices in everyday (profitable/efficient) service provision. Moreover, the NDIS and RACF regulatory frameworks are focused on penalising service providers (which in practice rarely occurs) and there is no option for redress for victims of restrictive practices.
- 6.16. Hinging legality of restrictive practices on ‘capacity’ reinforces discriminatory ideals of mental capacity that disadvantage individuals with cognitive and psychosocial disabilities. Beyond this, it reinforces broader liberal constructions of legal capacity that have historically disadvantaged numerous marginalised populations (e.g. First Nations people, poor people, women) and narrowed access to property, resources and political participation to a minority of privileged people.²⁷⁹ Legality contributes to the normalisation of violence and control in service contexts, making it more difficult for individuals to understand when harmful behaviour is wrong and unjust (including unauthorised restrictive practices). Legality of restrictive practices situates restrictive practices outside of criminal and civil legal understandings of violence and thus positions those subject to them as incomprehensible as victims and not legally entitled to redress (we return to this below when we discuss legal violence). At the same time, in being framed as benevolent, protective and therapeutic (indeed, the very name of the common law doctrine authorising restrictive practices ‘*parens patriae*’ means ‘parent of the state’ or ‘parent of the nation’), legality of restrictive practices positions the justice system and the state as rescuer. This dynamic is particularly problematic in relation to First Nations people. If disability is subject to restrictive practices, it:

... vindicates the settler colonial project insofar as it masks the fact that across many Anglo jurisdictions Indigenous sovereignty has never been ceded by

*pathologising Indigenous and First Nations criminalised disabled people as a problem to be fixed and positioning settler colonial society and criminal justice systems as rescuer, while eliding the ways in which they are complicit in constructing them as 'abnormal.'*²⁸⁰

- 6.17. Understanding restrictive practices as a form of legal violence has one key implication. Unlike other forms of violence that are unlawful, such as sexual assault or domestic violence, restrictive practices are a form of legal violence. While it might be impossible to completely obliterate all violence, the perverse logic in regulating restrictive practices is that their use is enabled by law and within the control of lawmakers to prohibit. Legal and justice systems work to protect perpetrators from accountability and exclude victim-survivors from redress.

Ableist Legal Violence

- 6.18. Restrictive practices can be more specifically understood as an ableist form of legal violence.
- 6.19. Steele offers the concept of 'disability-specific lawful violence' to refer to non-consensual interventions in the bodies and lives of people with disability that are permitted by law specifically on the basis of disability (or characteristics associated with disability, such as riskiness or mental incapacity).²⁸¹
- 6.20. Restrictive practices are an example of disability-specific lawful violence.
- 6.21. First, laws authorising third party consent to restrictive practices and laws excluding some individuals who use restrictive practices from criminal responsibility and civil liability are premised on assumptions of mental incapacity linked to disability and the need for people with disability to be subject to protection and control by reason of their disability. For example, the common law *parens doctrine* is premised on the assumption that people with cognitive and psychosocial disability lack the capacity to make their own decisions and by reason of this are vulnerable and thus need others to protect them by making decisions on their behalf.²⁸² As a further example, the doctrine of necessity in relation to people with disability is premised on the assumption that their incapacity to look after their own welfare and health gives rise to an ongoing emergency that requires intervention by third parties for their own protection and wellbeing.²⁸³ Second, laws regulating use of restrictive practices at the level of service systems are discriminatory because the service systems to which they apply are themselves specific to people with disability (NDIS) or overwhelmingly apply to people with disability (RACFs).
- 6.22. In being disability-specific, the legal violence of restrictive practices can only ever be perpetrated against people with disability, thus exposing people with disability to additional legal avenues for violence as compared to people without disability.
- 6.23. Moreover, the disability-specific legal violence of restrictive practices highlights how ableism is built into the doctrine (rather than merely the application) of law. There are entire pieces of legislation and associated tribunals (mental health, guardianship) that regulate violence against people with disability. Yet, even deeper than legal doctrine, this ableism is also built into foundational legal concepts that structure legal rights and legal relations, such as 'capacity' and 'consent'. Therefore, analysing restrictive practices as ableist legal

violence can illuminate the complicity of law, justice systems and the State at individual and structural levels in violence against people with disability. This has three key implications.

- 6.24. First, legal and justice systems contribute to structural discrimination, segregation and violence that is also apparent throughout a variety of systems including in education (segregated schools), housing (segregated accommodation arrangements), employment (segregated employment) and transport (segregated transport) systems. This legal segregation gives rise to dehumanisation, as explained by Roper et al in the specific context of mental health laws:

Dehumanisation involves viewing individuals through a particular lens, labelling them, othering and systematic exclusion ...

Mental health laws are symbolic of dehumanisation because they create a legal space that is outside the scope of justice, where operations of human rights and ethics afforded to other human beings are suspended. ... These laws symbolically declare individuals governed by them to be 'morally irresponsible', and in the process, the laws are positioned as enabling the provision of benevolent and protective care. In the application of mental health laws, decisions about who gets to keep their human rights and who does not happen through someone else declaring whether or not we are capable of consenting to treatment. If deemed to lack capacity to consent, under mental health laws we are governed by this 'other' legal space, we are no longer part of the moral community, we are not moral, thinking persons, we have been legally defined as non-thinking, non-feeling.²⁸⁴

- 6.25. Second, law contributes to epistemic violence against people with disability. Laws on restrictive practices contribute to hermeneutical epistemic injustice (discussed in Section 5 in the context of epistemic violence) against people with disability. This is because law fails to provide the interpretive tools to see restrictive practices as violence. Further, law compounds the epistemic injustice associated with the use of restrictive practices, because laws authorising third party consent to restrictive practices explicitly remove from people with disability both the opportunity to express their choices about their bodies and lives and the opportunity to have their choices recognised by others. Moreover, laws excluding some individuals who use restrictive practices from criminal responsibility and civil liability categorically deny people subject to third party consent the opportunity to voice their violation in criminal and civil justice systems.
- 6.26. Third, ableism is deeply entrenched in our systems of law and justice which we might intuitively turn to for protection against violence. Thus, we cannot assume that we can rely on legal and justice systems to prevent and redress violence and unseat cultural attitudes towards people with disability. Transformative change of legal and justice systems is required (including at the deeper levels of jurisdictions and foundational legal concepts). Moreover, redress schemes will need to be introduced because existing civil laws for redress will be ineffective. This has been the case with redress of historical eugenics sterilisation in the US, Scandinavia and Canada.²⁸⁵ Further, we should also consider non-legal and community-based approaches to redress and moral repair. In particular, the role of the State in restrictive practices means redress must go beyond an individualised/privatised process between individual victims, and instead engage collective and transformative processes that engage the broader community and Government. This might draw on transitional justice frameworks that have been utilised in post-conflict contexts, and on memorialisation, apologies, public education and sites of conscience that engage

the community in an ongoing way.²⁸⁶ The complicity of the legal profession requires further exploration and reflection by professional organisations and universities and consideration of how legal pedagogy can become a form of redress.²⁸⁷

- 6.27. Fourth, there must be recognition of State and legal system/profession complicity in ableism. This will be quite provocative because of the conventional framing of guardianship law, mental health law, and the common law doctrine of *parens patriae* as protective.
- 6.28. Fifth, it is important to note that many ableist legal concepts (e.g. ‘capacity’) and jurisdictions (e.g. mental health, guardianship) that provide the legal framing of gendered ableist legal violence are deeply embedded within the structure of the Australian legal system and our understandings of the rule of law (notably in terms of defining the limits of the legal system in relation to the non-disabled). Consequently, abolishing ableist legal violence will require transformative change of the entire legal system.²⁸⁸
- 6.29. Yet, to date, the Royal Commission has not confronted ableism in law, including in the context of restrictive practices. It has not considered prohibiting restrictive practices and abolishing legal frameworks that enable restrictive practices. Rather, taking an ‘on the ground’ focus on use which overlooks the prior legal authorisation of use, the Royal Commission refers to preventing and avoiding the use of restrictive practices:

*We would like to hear more about how the use of restrictive practices can be avoided. This includes hearing about alternative measures and strategies to restrictive practices to ensure people are safe and protected from harm.*²⁸⁹

- 6.30. To ‘avoid’ is to keep clear of something that exists. Thus, the Royal Commission’s framing of the issue in terms of avoidance (rather than prohibition and abolition) implicitly assumes the continued existence and use of restrictive practices, albeit potentially reduced. In a similar vein, the Royal Commission also states in the Restrictive Practices Issues Paper:

*We are interested in understanding how laws, policies and practices that apply to restrictive practices can better support and enable people with disability across their lives.*²⁹⁰

This statement is concerning because it gives rise to a perverse logic of achieving empowerment and support for people with disability through violence.

NDIS and Legal Violence

- 6.31. The NDIS is a universal scheme that funds ‘reasonable and necessary’ supports for Australians with permanent and significant disability, and which is currently being rolled out across Australia.²⁹¹ The NDIS Act (2013) clearly articulates that one of the objects of the NDIS is to ‘give effect to Australia’s obligations under the Convention on the Rights of Persons with Disabilities’.²⁹² Moreover, it has been framed as enhancing autonomy and inclusion of people with disability; the objects of the NDIS Act (2013) include:

*support the independence and social and economic participation of people with disability; ...
enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports;*²⁹³

- 6.32. Despite its ideals, the NDIS regulates, rather than prohibits, restrictive practices through the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018, in concert with State/Territory substitute decision-making laws. In order to use restrictive practices, NDIS providers must provide the NDISQSC with a behaviour support plan²⁹⁴ which meets certain requirements.²⁹⁵
- 6.33. The NDISQSC was established by s 181A of the National Disability Insurance Scheme Act 2013 (Cth) and assists the National Disability Insurance Scheme Quality and Safeguarding Commissioner in their functions.²⁹⁶ The Commissioner's core functions include: 'uphold[ing] the rights of, and promote the health, safety and wellbeing of, people with disability receiving supports or services, including those received under the National Disability Insurance Scheme'; 'develop[ing] a nationally consistent approach to managing quality and safeguards for people with disability receiving supports or services, including those received under the National Disability Insurance Scheme'; 'secur[ing] compliance with this Act through effective compliance and enforcement arrangements'; and 'promot[ing] continuous improvement amongst NDIS providers and the delivery of progressively higher standards of supports and services to people with disability.'²⁹⁷ The Commissioner's functions also include: 'provid[ing] leadership in relation to behaviour support, and in the reduction and elimination of the use of restrictive practices, by NDIS providers' ('behaviour support function');²⁹⁸ investigate and resolve complaints ('complaints function');²⁹⁹ and monitor compliance with conditions of registration ('registration and reportable incidents function').³⁰⁰
- 6.34. The NDISQSC is framed as the core solution to addressing the use of restrictive practices in disability services. Yet, its functions are clearly contradictory in terms of protecting people with disability from the violence of restrictive practices – upholding rights of people with disability at the same time as enabling restrictive practices, enabling restrictive practices at the same time as resolving complaints about their use – and this shows that one of the core (albeit unwritten) functions of NDISQSC is to regulate violence against people with disability through restrictive practices. Moreover, the NDISQSC's 'behaviour support function' gives rise to an individualised and beneficial understanding of restrictive practices as being to help specific individuals in response to their behaviour within a macro context of reducing the overall use of restrictive practices.
- 6.35. The role of NDISQSC in enabling violence through restrictive practices is also supported by its management of reportable incidents under its registration and reportable incidents function. 'Reportable incident' is defined as: 'the death of a person with disability'; 'serious injury of a person with disability'; 'abuse or neglect of a person with disability'; 'unlawful sexual or physical contact with, or assault of, a person with disability'; 'sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity'; and 'use of a restrictive practice in relation to a person with disability, other than where the use is in accordance with an authorisation (however described) of a State or Territory in relation to the person.'³⁰¹ It is striking that each form of reportable incident is not qualified by the authorisation of its perpetration with the exception of restrictive practices. This gives rise to a division between authorised and unauthorised restrictive practices.
- 6.36. In its most recent Activity Report, the NDISQSC notes in general that:

*The overwhelming majority of incidents that are reported to the NDIS Commission involve the use of restrictive practices on people with disability that have not been authorised by state and territory authorities, or where plans to promote positive behaviour supports are not in place for that person.*³⁰²

- 6.37. In particular, it notes that: ‘Reporting of Unauthorised use of Restrictive Practices (URP) represents 98.6% of all reportable incidents reported to the NDIS Commission.’³⁰³
- 6.38. There are four implications from the NDIS regulatory framework for restrictive practices. One is that the NDISQSC does not take action against NDIS-registered providers of support who use authorised restrictive practices, such that restrictive practices (when authorised) are explicitly permitted by the NDISQSC.
- 6.39. Second, while unauthorised restrictive practices are technically not allowed, in practice they are implicitly permissible because there is a high number of unauthorised restrictive practices that are reported, yet NDISQSC is not taking regulatory action against these.
- 6.40. Third, there is an absence in the National Disability Insurance Scheme Act 2013 (Cth) of options for redress for victims subject to unauthorised restrictive practices. Instead, the focus is on sanctions against providers which, as per the second point, are not being enforced anyway. NDIA ‘Performance Reports’³⁰⁴ provide only minimal gender-disaggregated data, making it difficult to know the extent of reportable incidents and unauthorised restrictive practices in relation to women. Thus, arguably ‘unauthorised’ restrictive practices become a separate category of ‘legitimate’ restrictive practices because the effect of being unauthorised is not to attract criminal or civil legal penalty. Instead, a regulatory response is prompted. However, the data shows the overwhelming response in such cases is not to recognise this as unlawful and unjust (let alone violence). In the NDIS legislative framework, restrictive practices are either permitted de jure or de facto.
- 6.41. Fourth, as discussed in Section 4, the regulation of restrictive practices by NDISQSC is premised on a division between interventions for medical conditions and behaviours of concern where only interventions for the latter will fit within the NDIS definition of restrictive practices. This division is not scientifically objective – it is socially and economically contingent and gendered – and there is significant scope for coercive interventions to be framed as required for medical conditions and thus completely outside of the NDISQSC regulatory framework. We will provide further discussion of the NDIS and restrictive practices in our forthcoming submission on sexual and reproductive rights.

Gendered Ableist Legal Violence

- 6.42. Restrictive practices can be even more specifically understood as a gendered ableist form of legal violence.
- 6.43. First, the common law doctrine of *parens patriae* which is the source of judicial and tribunal authority to decide on restrictive practices (guardianship legislation is a modern legislative rendition of a jurisdiction that was earlier exercised by supreme courts³⁰⁵) means ‘parent of the state’ or ‘parent of the nation’. It is understood in highly gendered terms as modelled on the familial authority of the father over the vulnerable child in the private sphere of the home. This is apparent in the judicial discussion of the exclusion of the principle of open justice from courts where they are applying the common law doctrine of *parens patriae*. French CJ in *Hogan v Hinch* stated:

*The jurisdiction of courts in relation to wards of the State and mentally ill people was historically an exception to the general rule that proceedings should be held in public because the jurisdiction exercised in such cases was “parental and administrative, and the disposal of controverted questions ... an incident only in the jurisdiction”.*³⁰⁶

- 6.44. Chief Justice French cited the decision of *Scott v Scott*. In *Scott v Scott*, Viscount Haldane LC explained why the court's work in relation to the common law doctrine of *parens patriae* is distinct to the general practice of open courts:

The case of wards of Court and lunatics stands on a different footing. There the judge who is administering their affairs, in the exercise of what has been called a paternal jurisdiction delegated to him from the Crown through the Lord Chancellor, is not sitting merely to decide a contested question. His position as an administrator as well as judge may require the application of another and overriding principle to regulate his procedure in the interest of those whose affairs are in his charge.

... While the broad principle is that the Courts of this country must, as between parties, administer justice in public, this principle is subject to apparent exceptions, such as those to which I have referred. But the exceptions are themselves the outcome of a yet more fundamental principle that the chief object of Courts of justice must be to secure that justice is done. In the two cases of wards of Court and of lunatics the Court is really sitting primarily to guard the interests of the ward or the lunatic. Its jurisdiction is in this respect parental and administrative, and the disposal of controverted questions is an incident only in the jurisdiction. It may often be necessary, in order to attain its primary object, that the Court should exclude the public. The broad principle which ordinarily governs it therefore yields to the paramount duty, which is the care of the ward or the lunatic.³⁰⁷

- 6.45. In a similar vein, Lord Shaw of Dunfermline in *Scott v Scott* stated in relation to 'suits affecting wards' and 'lunacy proceedings':

*these cases, my Lords, depend upon the familiar principle that the jurisdiction over wards and lunatics is exercised by the judges as representing His Majesty as *parens patriae*. The affairs are truly private affairs; the transactions are transactions truly *intra familiam*; and it has long been recognized that an appeal for the protection of the Court in the case of such persons does not involve the consequence of placing in the light of publicity their truly domestic affairs.³⁰⁸*

- 6.46. Also in *Scott v Scott*, Earl of Halsbury stated:

There are three different exceptions commonly so called, though in my judgment two of them are no exceptions at all. The first is wardship and the relation between guardian and ward, and the second is the care and treatment of lunatics.

My Lords, neither of these, for a reason that hardly requires to be stated, forms part of the public administration of justice at all.³⁰⁹

- 6.47. This judicial commentary highlights that the common law doctrine of *parens patriae* positions the court as inherently benevolent and as coming to the rescue of helpless and vulnerable people with disability in order to protect them from threats to their safety and wellbeing external to the justice system. When courts exercise the jurisdiction provided by the common law doctrine of *parens patriae* the very nature and purpose of the court shifts, from being situated in the public sphere and exercising justice as an arm of the state for

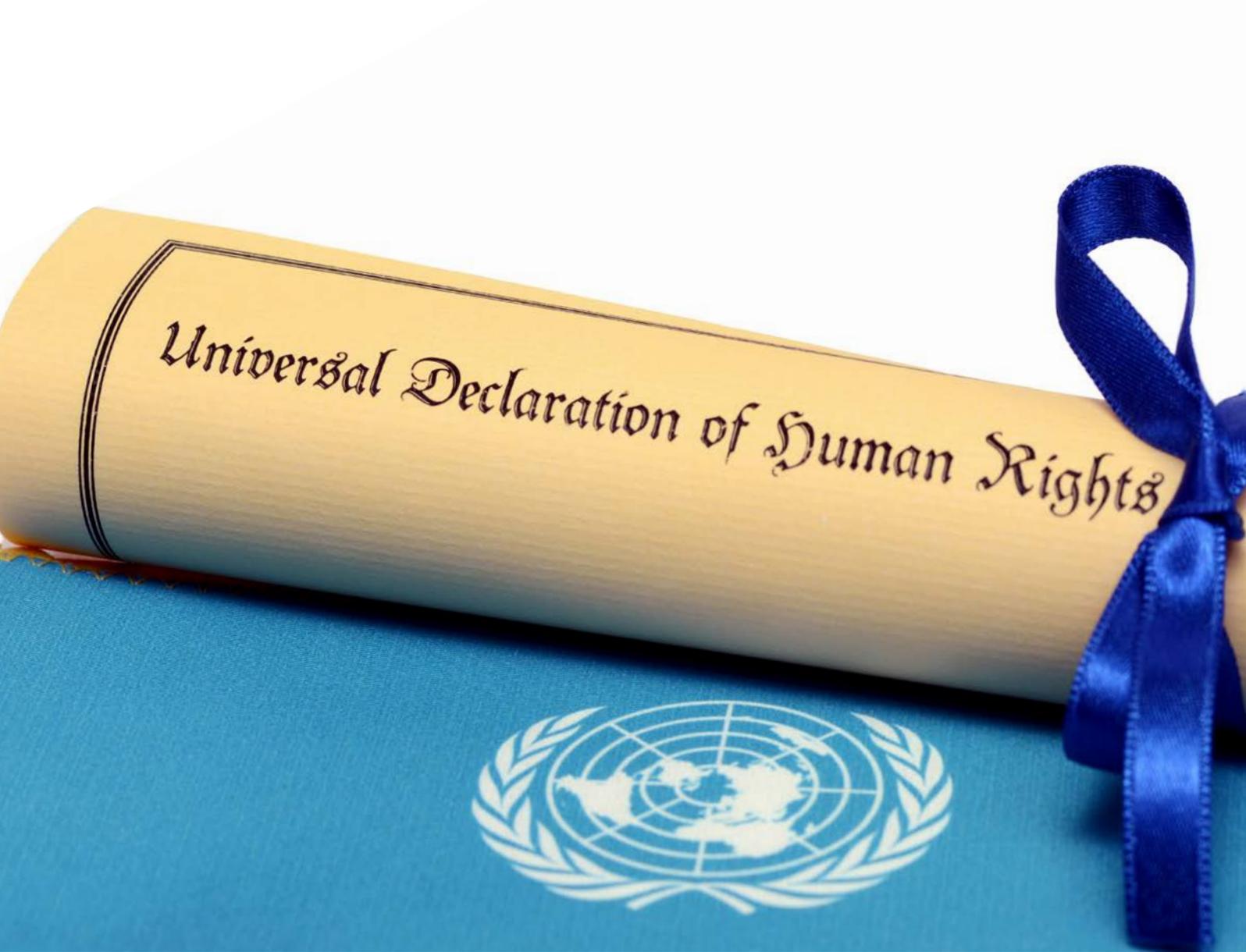
the benefit of the broader public, to being situated in the private sphere and exercising justice as a father to a child. There are three concerns with this approach to the common law *parens patriae* doctrine that demonstrate the gendered ableist violence of restrictive practices.

- 6.48. First, the doctrine relies on a medicalised and ableist understanding of people with disability as inherently violable (by forces external to the justice system) because of the inherent incapacity and vulnerability associated with their disability. Yet, this legal construction of people with disability renders them violable through the courts ordering the use of restrictive practices. Second, the court's legal construction as the private family home and judge's construction as a father figure is premised on the assumption that within the home the father is automatically loving, kind and protective to his family. This assumption has been challenged by decades of feminist activism and feminist legal scholarship that has highlighted violence within the family home and perpetrated by fathers and how the artificiality of the public/private divide serves to conceal violence within domesticated settings, protect male perpetrators from accountability, and exclude victims-survivors from redress in the justice system. This legal construction of the judge justifies their role in regulating restrictive practices as a benevolent and protective and ultimately non-violent act, and constructs the court itself as a space of safety and non-violence (i.e., that violence happens somewhere 'out there', but not in the courtroom). The common law doctrine of *parens patriae* is legal patriarchy writ large. Third, the combination of the legal construction of people with disability as vulnerable children, the judge as protective father and court as non-violent home establishes the distinctiveness of the court's exercise of this jurisdiction as opposed to other jurisdiction, and thus justifies the absence of public scrutiny of courts applying the common law doctrine of *parens patriae* (as per the open justice principle). This distinctiveness justifies the lack of public transparency and accountability for its role in ordering violence of restrictive practices and this lack of public scrutiny coupled with the court's role in ordering violence ultimately contributes to the reduction of people with disability to less than full legal subjects and citizens and their exclusion from full political community and humanness.³¹⁰ It is also important to note that the key dynamics of the child, father and family home underpinning the legal violence in the common law doctrine of *parens patriae* also gives rise to settler colonial violence, insofar as it positions Indigenous disabled people as childlike, the judge as rescuer and protector of Indigenous people and the court of the settler colonial white nation state as non-violent. For example, Mills and Lefrancois note that 'the child functions as a metaphor for colonized, racialized, psychiatrized and disabled peoples'³¹¹ and that 'metaphoric of child/colony is contingent on patriarchal domination, where the familial ruling of the husband/father is naturalized as a model for colonial domination'.³¹²
- 6.49. It is important that the Royal Commission consider the ableist and patriarchal common law *parens patriae* doctrine. The doctrine has an enduring existence beyond any legislative reforms to mental health or guardianship legislation. Even if mental health and guardianship legislation was completely abolished, the common law doctrine would continue to operate unless explicitly excluded through legislation. Yet, this jurisdiction is rarely discussed and scrutinised in government inquiries on restrictive practices, with the focus instead being on guardianship and mental health legislative frameworks. It is for this reason that in recommending the abolition of legal frameworks for restrictive practices and substituted decision making, WWDA specifically recommends legislative reform to explicitly exclude the operation of the common law doctrine of *parens patriae* in relation to restrictive practices.
- 6.50. Additional to concerns with the common law doctrine of *parens patriae*, restrictive practices are a form of gendered ableist legal violence because in the course of

authorising restrictive practices, courts and tribunals situate women and girls with disability outside of gendered norms of reproduction, menstruation, sexuality and parenting.³¹³ This is particularly apparent in relation to Family Court decisions on sterilisation, as Steele and Goldblatt summarise here:

During the 1980s and 1990s, there were a number of FCA decisions and Australian High Court decisions concerning sterilization of girls with disabilities. These decisions illustrate ... problematic associations between disability, gender, and menstruation ... They portray girls as risky and dangerous by reason of their leaky bodies and irrational behaviour attributed to their menstruation (Steele 2008, 2016). The girls are portrayed as being unable to comprehend menstruation as part of their bodies' processes. For example, in one decision the judge stated: "[during menstruation] L threw herself on the floor and scratched herself on the legs and face, . . . she would lash out if someone tried to assist her so they might be injured and she would claw her own body with her fingers until she drew blood" (Re BW (unreported, FamCA, Chisholm J, 10 April 1995) at 10). In this context, sterilization is viewed by judges as being in the girls' best interests because it will protect them from their erratic and risky behaviour associated with menstruation and protect them from pregnancy and childbirth, including pregnancy arising from sexual abuse. Judges have also expressed need to use sterilization to avoid the "frightening and unnecessary experience" of being in public with visible bleeding (Re Jane (1988) 12 Fam LR 662 at 681). The judges also approach sterilization as being in the best interests of the child because it will protect parents and carers from the burden of care imposed by their superfluous menstruation and related behaviour, and the burden of caring for any child born (Steele 2008). For example, Warnick J described sterilization of Katie as "lessen[ing] the physical burdens for the mother, in particular by decreasing the number of changes necessary in toileting" (Re Katie (unreported, FamCA, Warnick J, 30 November 1995) at 15). Moreover, in some decisions, the Family Court rejected alternatives to menstrual management on the basis that they would not be successful. For example, in one decision Cook J dismissed a menstrual management education program because he considered it "difficult to avoid the feeling, that here, perhaps too much reliance is being placed on the success of what are possibly imperfect programs, imperfectly administered and monitored upon, sadly, an imperfect subject" (Re a Teenager (1988) 13 Fam LR 85 at 94).³¹⁴

- 6.51. Understanding restrictive practices as gendered ableist legal violence underscores the importance of complete prohibition of restrictive practices through widespread legislative reform, the significance of considering restrictive practices specifically in relation to women and girls with disability, and the necessity for the Royal Commission to specifically engage in its issues papers, public hearings and other work with the legal and justice dimensions and contexts of restrictive practices. As long as the Royal Commission focuses only on how restrictive practices are used 'on the ground', it will overlook the significant dimension of their violence and also be unable to formulate recommendations that prevent this violence from continuing.



7 RESTRICTIVE PRACTICES - A VIOLATION OF HUMAN RIGHTS

7. RESTRICTIVE PRACTICES – A VIOLATION OF HUMAN RIGHTS

- 7.1. This section provides an overview of an international human rights framework for responding to restrictive practices as violence against women and girls with disability.
- 7.2. Restrictive practices are human rights violations. Their use and legality violate rights of people with disability to equality and non-discrimination, legal capacity, freedom from violence and torture, personal integrity, liberty, and independent living and community inclusion as provided by the CRPD, and other international human rights instruments. Their longer-term impacts that are apparent from our approach to restrictive practices as gendered ableist legal violence, notably their impacts on people with disability's flourishing, social, economic and civic participation, experiences of intimacy and family formation, engage a broader range of human rights.
- 7.3. Violence against women and girls with disability is recognised as a significant human rights problem in Australia, and restrictive practices (including non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion) are a core aspect of this violence. Following her visit to Australia, the Special Rapporteur on Violence Against Women noted the following regarding its causes and consequences:

Compared to their peers, women with disabilities experience significantly higher levels of all forms of violence more intensely and frequently and are subjected to such violence by a greater number of perpetrators. Their experiences of violence last over a longer period of time and more severe injuries result from that violence. Beyond forms of violence such as sexual abuse, including rape and domestic violence, women and girls with disabilities are at particular risk of practices violating their sexual and reproductive rights, such as forced sterilization, forced abortion and forced contraception. On forced sterilization, the Special Rapporteur echoes concerns raised consistently by the United Nations human rights mechanisms, which have consistently recommended the adoption of legislation prohibiting sterilization in the absence of prior, fully informed and free consent, except where there is a serious threat to life or health.³¹⁵

- 7.4. The Special Rapporteur on Violence Against Women also noted the failures of laws and justice systems to prevent and redress violence:

The issue is not addressed adequately in legislation or policy frameworks on violence against women or women with disabilities, leading to an overall lack of accountability and impunity for perpetrators. There is no comprehensive and properly intersectional human rights policy framework to address all forms of violence against people with disabilities, especially women, and no legal, administrative or policy framework for the prevention, protection, investigation and prosecution of all forms of violence, exploitation, and abuse of people with disabilities.

Women and girls with disabilities face accrued difficulties in accessing remedies. The Special Rapporteur received details of cases where service

*providers had not reported some cases, or where the police had refused to investigate allegations of sexual violence because the alleged victims had a mental disability which they had decided would be problematic in terms of gathering evidence.*³¹⁶

- 7.5. It is fundamental to the Royal Commission’s work on restrictive practices (including reports, community forums, stakeholder engagement, hearings, publications, findings and recommendations) that it centres the human rights of people with disability to: equality and non-discrimination; freedom from violence and torture; legal capacity; personal integrity; liberty; and independent living and community inclusion as provided by the CRPD. This is in line with its Terms of Reference, which are based in the context of the CRPD.
- 7.6. Relatedly, the Royal Commission must consider all of the relevant recommendations made to Australia from the international human rights treaty monitoring bodies, not just those stemming from the UN CRPD Committee, in its work on restrictive practices. This approach recognises that Australia is a signatory to seven core international human rights treaties, each of which contain obligations relating to people with disability (including women and girls with disability), and which are expected to be viewed and implemented as complementary mechanisms through which to create a holistic framework of rights protection and response for all people with disability.
- 7.7. This section provides an overview of an international human rights framework for responding to restrictive practices as violence against women and girls with disability, which supports the recommendations in Section 1. It begins with a general overview of the CRPD in relation to women and girls with disability and identifies some risks about counter-productive engagement with human rights by Government and law reform inquiries. Next, this section explores human rights as they relate to restrictive practices in relation to women and girls with disability.

Human Rights Generally

- 7.8. Australia is a signatory to seven core international human rights treaties.³¹⁷ As a party to these treaties, Australia has chosen to be bound by the treaty requirements and has an international obligation to implement the treaty provisions through its laws and policies. Together, the seven international human rights treaties to which Australia is a party – along with their Optional Protocols,³¹⁸ General Comments³¹⁹ and recommendations adopted by the bodies monitoring their implementation – provide the framework to delineate the obligations and responsibilities of Governments and other duty-bearers to comprehensively promote the human rights of women and girls with disability, including in relation to violence.
- 7.9. It is encouraging that the Royal Commission’s Terms of Reference explicitly embed international human rights and explicitly reference the CRPD:

RECOGNISING that people with disability are: equal citizens and have the right to the full and equal enjoyment of all human rights and fundamental freedoms, including respect for their inherent dignity and individual autonomy. ...

AND Australia has international obligations to take appropriate legislative, administrative and other measures to promote the human rights of people

*with disability, including to protect people with disability from all forms of exploitation, violence and abuse under the Convention on the Rights of Persons with Disabilities.*³²⁰

- 7.10. Moreover, while it is important that the work of the Royal Commission is framed within and underpinned specifically by the CRPD, the Royal Commission should also engage with other human rights treaties. It should be understood that implementation of the seven core international human rights treaties to which Australia is a party is not mutually exclusive. These treaties are expected to be viewed and implemented as complementary mechanisms through which to create a holistic framework of rights protection and response for all people with disability.³²¹ For example, for more than a decade, several of the international human rights treaty monitoring bodies have made recommendations to Australia in relation to people with disability, including specific recommendations relating to women and girls with disability. These include recommendations in relation to restrictive practices (notably sterilisation) as well as violence against women and girls with disability more broadly. We urge the Royal Commission to consider all of these recommendations in its work, not just those stemming from the CRPD.
- 7.11. To the extent that the Royal Commission focuses on the CRPD, we note that this treaty is clear on gender equality. The CRPD recognises gender as one of the most important categories of social organisation. It expressly states the requirement to incorporate a gender perspective in all efforts to promote the human rights of people with disability, meaning that the rights of women and girls with disability must be addressed when interpreting and implementing every article of the CRPD.
- 7.12. The CRPD prioritises women and girls with disability as a group warranting specific attention and additional measures. It obliges Governments to take positive actions and measures to ensure that disabled women and girls enjoy all human rights and fundamental freedoms. It clarifies the need to ensure that national policies, frameworks and strategies explicitly recognise the impact of multiple discriminations caused by the intersection of gender and disability, and that such policies and frameworks include focused, gender-specific measures to ensure that women and girls with disability experience full and effective enjoyment of their human rights.
- 7.13. Despite the obligations of the CRPD in relation to women and girls with disability, it remains the case that in Australian legislative, policy and service contexts, people with disability are still often treated as asexual, genderless human beings. This gender-neutrality can (and does) create and perpetuate the consequences of gender-based discrimination and can (and does) lead to misleading analyses of issues and/or inaccurate assessments of likely policy outcomes. This is particularly concerning in relation to restrictive practices regarding women and girls' embodied and social experiences that are gendered as female – such as menstruation, sexual assault and domestic violence victimisation, sexuality and intimacy, reproduction, mothering, menopause, and gynaecological cancers, including non-consensual and coercive sterilisation, menstrual suppression, contraception, abortion, forced child removal, and denial of support for sexual activity and intimate relationships.
- 7.14. Article 6 of the CRPD (Women with Disabilities), as a cross-cutting article, means that the rights of women with disability must be specifically identified and addressed in all measures in the implementation and monitoring of the CRPD, including in relation to Articles 12, 14, 15, 16, and 17. It is clear that in the Australian context, this is yet to occur.

- 7.15. For a comprehensive discussion of the human rights approach to violence, abuse, neglect and exploitation against people with disability, including women and girls with disability, we draw the attention of the Royal Commission to our submission, as part of Disabled People's Organisations Australia (DPO Australia, formerly the Australian Cross Disability Alliance) to the Senate Institutional Violence Inquiry.³²² This submission comprehensively: examines the human rights conceptualisation of 'disability', 'intersectionality' and 'violence against people with disability'; provides information on the scope and prevalence of violence, including gendered disability violence; outlines human rights violations that constitute violence, abuse, neglect and exploitation against people with disability; and highlights failures in the Australian legislative, policy and service landscape in relation to violence. We also draw the attention of the Royal Commission to the paper, 'Preventing Violence against Women and Girls with Disabilities: Integrating A Human Rights Perspective'.³²³ This paper elaborates on key points made in this submission. We also draw the attention of the Royal Commission to the 'Women with Disabilities Australia (WWDA) Position Statement: The Right to Freedom from All Forms of Violence'.³²⁴ This Statement outlines key evidence concerning ongoing violations of Australian women and girls with disabilities' right to freedom from all forms of violence, and highlights specific human rights obligations to ensure that all women and girls with disability can realise their right to freedom from all forms of violence, abuse, exploitation and neglect.
- 7.16. Consistent with CRPD General Comment 3 (Women and girls with disabilities) and CRPD General Comment 7 (The participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention), it is critical that the Royal Commission provide safe and supportive spaces to enable women and girls with disability to engage with the Royal Commission without fear of retribution. And, as a prior matter, it is critical that the Royal Commission provide opportunities for exploration specifically of violence against women and girls with disability, including the gendered dynamics of violence and the different contexts, forms and impacts of violence. To date this has not occurred through the issues papers and public hearings.

Some Cautionary Notes on How the Royal Commission Engages with International Human Rights

- 7.17. It is very encouraging that the Royal Commission is explicitly embedding international human rights in its Terms of Reference and has engaged with human rights through its issues papers and research program. Here we raise some cautionary notes based on our observations of the counter-productive effects arising from how earlier Government inquiries and law reform projects have engaged with the CRPD.
- 7.18. The first point of caution is that the Royal Commission must ensure it takes a holistic approach to human rights of people with disability, including women and girls with disability. All human rights must be considered, including those in the CRPD and in mainstream human rights instruments, such as the International Covenant on Civil and Political Rights (ICCPR). An approach that considers all human rights can be contrasted to an approach that cherry-picks those human rights (e.g. rights to 'dignity', 'health') that can be interpreted in ways that do not disrupt a medicalised approach to people with disability and allow the structural status quo of confinement, segregation and institutionalisation to continue (albeit with 'improvements' in how care is provided to individuals within these existing and untransformed structural conditions). The Senate Sterilisation Inquiry³²⁵ is a prime example of a selective/convenience approach to human rights. In that inquiry, the

Committee selectively drew upon CRPD human rights such as the right to health (although not rights to non-discrimination, legal capacity and personal integrity) to recommend a 'human rights' test for judicial approval of non-consensual sterilisation, in a context where UN treaty body Committees have consistently recognised sterilisation as a grave human rights abuse and called on the Australian Government to prohibit the practice.³²⁶

- 7.19. While we are hopeful the Royal Commission will not take such a selective/convenience approach, we do note that in the Health Care and Services for People with Cognitive Disability Issues Paper, the Royal Commission focuses on Article 25 and the right to health as an enabler, as well as focusing on the ability of people to access physical healthcare.³²⁷ While not disputing this right is central to equality and freedom from violence (notably in light of premature deaths of people with intellectual disability due to denial of any or appropriate healthcare)³²⁸, the health care issues paper does not consider how 'health' (and even the 'right' to health) is used to justify violence. Article 25 (like all articles in the CRPD) needs to be read in conjunction with other CRPD articles and articles of other human rights documents, such as the ICCPR and Convention Against Torture (CAT), so that the realisation of the right to health does not undermine equality, autonomy/self-determination and freedom from violence. This omission is particularly concerning given that the health care issues paper did not consider gendered violence against women and girls with disability in health care settings, such as surgical procedures or prescribing in relation to non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion. This is also reflected in the observations of the Parliamentary Joint Committee on Human Rights regarding the Government's approach to the human rights compatibility of the RACF Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019; focusing on the right to health at the cost of rights related to violence.³²⁹
- 7.20. Another way in which the selective/convenience approach to international human rights might manifest is if the Royal Commission commits to taking a human rights-based approach, but then does not begin from the premise of what international human rights treaties actually state in relation to a particular aspect of violence against people with disability, instead retreating to debate whether that intervention is contrary to human rights at a domestic level and whether it is even violence. WWDA has observed this as occurring implicitly in relation to group homes, segregated education and psychotropic medication. It would be extremely concerning if the Royal Commission was to canvas, in future hearings, forums and papers, views about the value, benefits and human rights compliance of restrictive practices. Article 5 of the CRPD prohibits segregation on the basis of impairment, reflecting the established principle in international law that segregation is inherently unequal and discriminatory.³³⁰ The rights to exercise legal capacity, preserve personal integrity and be free of arbitrary detention have already been negotiated and agreed and outlined in legally binding international human rights law through the CRPD. In this context, the value/benefits/human rights compliance of restrictive practices should not be up for debate in the Royal Commission.
- 7.21. The second point of caution is that a human rights approach to people with disability should not sustain multiple standards of human rights that differentiate between disabled populations. The possibility for multiple standards is evident in the relatively narrow approach to what constitutes an institution for the purpose of advocacy and scholarship on deinstitutionalisation and Article 19 of the CRPD. For example, RACFs are generally only seen as institutions in relation to younger people with disability (and not for people living with dementia and older people with disability)³³¹ and prisons, juvenile justice facilities and immigration detention centres (all sites of confinement where many people

with disability reside) are typically excluded from the concept of the disability ‘institution.’ Instead, they are framed in terms of Articles 13, 14, and 15 which are focused on rights within institutions and legal processes leading up to admission to institutions, rather than deinstitutionalisation.³³² These inequalities are particularly concerning given the populations in these two examples are more likely to be older, racialised, Indigenous and/or poor people with disability.

- 7.22. The third caution is that the Royal Commission should not engage with human rights in an overly legalistic way and only when they are legally enforceable in Australia (i.e. a more legal/doctrinal approach to human rights). The technical legal approach to human rights, when used in a law reform context, can unnecessarily end up being directed towards interpreting out of the necessity or law reform. Indeed, this has been the problem in various State and Territory reviews of guardianship and mental health legislation, as well as the Senate Sterilisation Inquiry, where Australia’s interpretative declaration to Article 12 of the CRPD has been viewed as a limitation to realising Article 12 in recommendations for reform.³³³ These Interpretative Declarations, which include allowing for substitute decision-making and compulsory treatment, have been found to be hindering Australia’s ability to comply with the CRPD and are being used as a justification for violence (including through restrictive practices) and to deny people with disability their human rights. This is consistent with recommendations made to successive Australian Governments by the UN treaty monitoring bodies and by civil society organisations, including DPOs. This approach inevitably results in the conclusion that Australia technically either has not breached any obligations, or is not bound by the CRPD, which in turn perversely vindicates retaining the violent status quo. It would be a perverse situation if the Royal Commission’s recommendations on how to transform law and practice were limited by what is the current law (including the current domestic law of human rights). If such an approach were taken consistently across all aspects of Australian law, presumably no change to any laws would ever be possible because such changes would then be contrary to the existing laws. On a related note, we are concerned by Commissioner Sackville’s observations of human rights (particularly the CRPD) as “*informing the Royal Commission*”.³³⁴ The reference to ‘informing’ grossly understates the expectation that they will guide the Royal Commission’s work, in a broader context of the Australian government having obligations under the CRPD.
- 7.23. Legal technicalities aside, there is nothing preventing the Royal Commission from engaging with the CRPD as providing a moral and ethical framework to guide normative transformation of law and justice, medical, disability and welfare systems. Transformation is by definition unbound by current domestic law and practice on human rights. While the legal technicality approach to human rights might be appropriate in a court context where it is important to identify currently enforceable legal rights and obligations under Australian law, the most such an approach (as part of a broader engagement with human rights as providing a moral and ethical framework to guide normative transformation of law, and of justice, medical, disability and welfare systems) can do in an inquiry context is to highlight the extent of current obligations and compliance. It seems counter-productive that the current domestic legal enforceability of international human rights in the Royal Commission context, which is focused on making recommendations for change of existing legal frameworks, is determinative of the future legal status of a particular intervention. Instead, such analysis should be informing recommendations for the Australian Government to reform its laws so as to fully implement the CRPD in Australian law. To rely exclusively on a legal technicality approach to human rights is to deplete human rights of the rich ethical and moral ideals that underpin them.
- 7.24. The fourth caution relates to the use of human rights discourse by service providers. As discussed in Section 5, restrictive practices might occur in the course of routine service

delivery and be rationalised as achieving inclusion, participation, choice and safety for people with disability (particularly when provided in the context of the NDIS with its legislative human rights framing). The Royal Commission must not take at face value the commitment to human rights by service providers using restrictive practices. Instead, we encourage the Royal Commission to explore how human rights discourse (notably concepts of inclusion, participation, choice and safety) can be rationalised as co-existing with the use of restrictive practices by disability service providers, how human rights discourse might be co-opted for efficiency, convenience and economic gain for the benefit of service providers, and how the NDIS legislative framework with its neoliberal focus on choice and control facilitates this co-opting. This exploration is particularly necessary in relation to women and girls with disability, where norms of ability and gender diminish their agency and the economic and social value of their gendered reproductive, menstrual, familial, intimate, and sexual experiences so as to justify use of restrictive practices such as non-consensual sterilisation, menstrual suppression, contraception and abortion under the guise of inclusion, participation, choice and safety.

- 7.25. The final caution is that there might be some contexts in which the CRPD alone does not provide all the tools to grapple with the complexity of violence perpetrated against people with disability. In particular, as Steele has explored at length elsewhere,³³⁵ the CRPD might not provide a complete set of tools to fully understand and respond to settler colonial violence, structural violence, slow violence, the endurance of eugenics logic about disability, or violence against people with disability in the criminal justice context. The CRPD might consider drawing on other frameworks of justice, such as Indigenous justice frameworks, transformative justice and Disability Justice.

Use and Legality of Restrictive Practices as Human Rights Violations

- 7.26. Restrictive practices violate international human rights principles and standards of equality and non-discrimination as well as preventing realisation of multiple rights, including rights of people with disability to equality and non-discrimination, freedom from violence and torture, legal capacity, personal integrity, liberty, and independent living and community inclusion. It is concerning to WWDA that the Restrictive Practices Issues Paper does not highlight the fact that restrictive practices are in clear breach of the CRPD. Rather, quite equivocally, it is stated they ‘may’ constitute a human rights breach:

*People with disability have a right to be free from violence and abuse, and torture or cruel, inhumane or degrading treatment. People with disability also have rights to physical and mental integrity, liberty and autonomy. The use of restrictive practices may conflict with these human rights.*³³⁶

- 7.27. The UN CRPD Committee has overwhelmingly found restrictive practices (including non-consensual and coerced sterilisation and abortion) and substituted decision-making and compulsory treatment laws to be inconsistent with the CRPD and contrary to human rights provisions therein. As a result, the UN CRPD Committee has consistently urged States Parties to review such practices and related legislation and bring them in line with the CRPD. For example, Maker and McSherry summarise that:

The UN Committee on the Rights of Persons with Disabilities, which monitors implementation of the CRPD, has repeatedly expressed its concerns about the use of restraint. It has recommended action to reduce or abolish restraint in its ‘concluding observations’ on reports submitted to it from many States Parties to

*the Convention including Slovenia, Luxembourg, the United Kingdom, Ethiopia, Thailand, Croatia, Germany, Denmark, the Republic of Korea, Mexico, Kenya and Australia.*³³⁷

- 7.28. The issue of non-consensual and coerced sterilisation as a human rights violation has also been clearly articulated by the Committee on Elimination of Discrimination Against Women³³⁸ (UN CEDAW Committee).
- 7.29. We now turn to discuss how restrictive practices and related substituted decision-making and compulsory treatment laws violate specific rights in the CRPD.

Equality, Non-Discrimination and Participation

- 7.30. Laws that regulate restrictive practices, including substituted decision-making and compulsory treatment laws, violate the right to equality and non-discrimination against people with disability. Governments are required to abolish discriminatory laws that regulate restrictive practices and address the ableism and stigma that sustain the use of restrictive practices.
- 7.31. Equality and non-discrimination are among the most fundamental principles and rights of international human rights law. Because they are interconnected with human dignity, they are the cornerstones of all human rights. States Parties have an obligation to respect, protect and fulfil the right of all persons with disabilities to non-discrimination and equality. This means that States Parties must refrain from any action that discriminates against persons with disability.
- 7.32. The CRPD codifies a ‘human rights model’ of disability.³³⁹ This model is distinct to a medical or charity model found in earlier human rights instruments pertaining to disability. The UN CRPD Committee explains:

*The human rights model of disability recognizes that disability is a social construct and impairments must not be taken as a legitimate ground for the denial or restriction of human rights. It acknowledges that disability is one of several layers of identity. Hence, disability laws and policies must take the diversity of persons with disabilities into account. It also recognizes that human rights are interdependent, interrelated and indivisible.*³⁴⁰

- 7.33. This model ‘values impairment as part of human diversity and human dignity.’³⁴¹ The inherent dignity of the human being is the focus of the human rights model of disability, rather than any impairment. It ‘clarifies that impairment does not derogate human dignity nor does it encroach upon the disabled person’s status as a rights-bearer.’³⁴²
- 7.34. Equality and non-discrimination are found in the CRPD both as a general principle³⁴³ and as a right.³⁴⁴
- 7.35. Article 5(2) provides that Government must prohibit ‘all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.’ ‘Discrimination on the basis of disability’ is defined as: ‘any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis

with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.³⁴⁵ ‘Discrimination on all grounds’ is defined as:

*... all possible grounds of discrimination and their intersections must be taken into account. Possible grounds include but are not limited to: disability; health status; genetic or other predisposition towards illness; race; colour; descent; sex; pregnancy and maternity/paternity; civil; family or carer status; gender expression; sex; language; religion; political or other opinion; national, ethnic, indigenous or social origin; migrant, refugee or asylum status; belonging to a national minority; economic or property status; birth; and age, or a combination of any of those grounds or characteristics associated with any of those grounds.*³⁴⁶

- 7.36. The UN CRPD Committee in the context of its General Comment 6 (Equality and Non-discrimination) highlights the role of laws – and the paternalism underpinning them – as sustaining inequality and violence against people with disability:

*... laws and regulatory frameworks often remain imperfect and incomplete or ineffective, or reflect an inadequate understanding of the human rights model of disability. Many national laws and policies perpetuate the exclusion and isolation of and discrimination and violence against persons with disabilities. They often lack a recognition of multiple and intersectional discrimination or discrimination by association; fail to acknowledge that the denial of reasonable accommodation constitutes discrimination; and lack effective mechanisms of legal redress and reparation. Such laws and policies are commonly not regarded as disability-based discrimination because they are justified as being for the protection or care of the persons with a disability, or in their best interest.*³⁴⁷

- 7.37. While ableism is not mentioned in the CRPD, the Special Rapporteur on Disabilities, discusses the role of ableism in discrimination. The Special Rapporteur on Disabilities defines ‘ableism’ as:

*... a value system that considers certain typical characteristics of body and mind as essential for living a life of value. Based on strict standards of appearance, functioning and behaviour, ableist ways of thinking consider the disability experience as a misfortune that leads to suffering and disadvantage and invariably devalues human life.*³⁴⁸

She explains that ableism lies:

*... at the root of discriminatory practices, such as the sterilization of girls and women with disabilities, the segregation, institutionalization and deprivation of liberty of persons with disabilities in disability-specific facilities and the use of coercion on the basis of “need of treatment” or “risk to self or to others,” the denial of legal capacity on the basis of mental capacity, the denial of treatment on the basis of disability, or the failure to consider the extra costs of living with a disability.*³⁴⁹

- 7.38. The Special Rapporteur on Disabilities draws on the principle in the CRPD of inherent dignity to re-assert the entitlement of people with disability to full humanity:

*Life with a disability is a life worth living equal to others. Every person has a unique set of unrepeatable characteristics and experiences that make them irreplaceable and valuable. The lives of persons with disabilities are human lives and, consequently, endowed with inherent dignity. Persons with disabilities can live fulfilling lives and enjoy what gives life meaning.*³⁵⁰

- 7.39. She argues that addressing ableism is not simply about ‘awareness raising’, but rather requires ‘cultural transformation’:

*Given the cultural and societal challenges posed by ableism, neither awareness-raising programmes nor the generalization of anti-discrimination measures will alone suffice. What is needed is a cultural transformation of the way society relates to the difference of disability. That is a commitment to the recognition of persons with disabilities as equals on all terms, with the same rights and opportunities as everyone else in society. It is thus vital to reduce the distance between society’s views of disability and the narratives of those living with a disability. The devaluation of the lives of persons with disabilities comes partly from a historic inability to listen to what persons with disabilities have to say about themselves.*³⁵¹

- 7.40. Article 5(1) provides for the right to be equal before and under the law, which means they ‘have the right to be effectively protected and to positively engage.’³⁵² Laws that discriminate against people with disability violate Article 5(1) such that ‘there should be no laws that allow for specific denial, restriction or limitation of the rights of persons with disabilities, and that disability should be mainstreamed in all legislation and policies.’³⁵³ The right to ‘equal protection under the law’ is particularly significant in the context of substituted decision-making and compulsory treatment laws that treat people with disability unequally. The UN CRPD Committee states that ‘deprivation of liberty; torture or cruel, inhuman or degrading treatment or punishment; violence; and the forced treatment of persons with disabilities inside and outside of mental health facilities are ‘by definition discriminatory.’³⁵⁴

- 7.41. States Parties obligations in relation to equality and non-discrimination extend to the abolition of discriminatory laws, such as those that permit restrictive practices. As the UN CRPD Committee states:

*States parties shall modify or abolish existing laws, regulations, customs and practices that constitute such discrimination. The Committee has often given examples in that regard including: guardianship laws and other rules infringing upon the right to legal capacity; mental health laws that legitimize forced institutionalization and forced treatment, which are discriminatory and must be abolished; non-consensual sterilization of women and girls with disabilities; inaccessible housing and institutionalization policy; segregated education laws and policies; and election laws that disenfranchise persons with disabilities.*³⁵⁵

- 7.42. As well as abolishing discriminatory laws, in implementing Article 5, States Parties are also required to: ‘[e]stablish accessible and effective redress mechanisms and ensure access to justice, on an equal basis with others, for victims of discrimination based on disability.’³⁵⁶

- 7.43. Through CRPD General Comment 6 (Equality and non-discrimination) the UN CRPD Committee has provided authoritative guidance on the implementation of, and intersection between other CRPD Articles including 12, 14, 15, 16, 17 and 19 and CRPD Article 5 (Equality and non-discrimination). The Committee has clarified for example, that:

Persons with disabilities can be disproportionately affected by violence, abuse and other cruel and degrading punishment, which can take the form of restraint or segregation as well as violent assault. The Committee is particularly concerned about the following acts committed against persons with disabilities, including children on the grounds of impairment, which by definition are discriminatory: separation of children with disabilities from their families and forced placement in institutions; deprivation of liberty; torture or cruel, inhuman or degrading treatment or punishment; violence; and the forced treatment of persons with disabilities inside and outside of mental health facilities. States parties must take all appropriate measures, to provide protection from and prevent all forms of exploitation, violence and abuse against persons with disabilities. Forced corrective disability treatments should be prohibited.³⁵⁷

7.44. People with disability, including women and girls with disability, have their rights articulated and upheld through all the international human rights treaties to which Australia is a party.³⁵⁸ Prior to the development and adoption of the CRPD, the application of human rights to the issues and concerns of people with disability were largely invisible and not addressed.³⁵⁹ The CRPD is a response to this lack of recognition of the rights of persons with disability. Until the CRPD, specific issues and concerns for women and girls with disability were mainly articulated, in varying degrees, within the jurisprudence developed under the CEDAW³⁶⁰ and the Convention on the Rights of the Child.³⁶¹

7.45. However, the CRPD explicitly acknowledges different layers or intersections of identity, through paragraph (p) of its preamble:

Concerned about the difficult conditions faced by persons with disabilities who are subject to multiple and aggravated forms of discrimination on the basis of race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, birth, age or other status.

7.46. Intersectionality is a key element of the human rights approach to disability required by the CRPD. Women and girls with disability are among those groups of persons with disability who most often experience multiple and intersectional discrimination. As the UN CRPD Committee observes:

There is strong evidence to show that women and girls with disabilities face barriers in most areas of life. These barriers create situations of multiple and intersecting forms of discrimination against women and girls with disabilities, in particular with regard to: equal access to education, economic opportunities, social interaction and justice; equal recognition before the law; and the ability to participate in politics and to exercise control over their own lives across a range of contexts, for example with regard to health care, including sexual and reproductive health services, and to where and with whom they wish to live.³⁶²

7.47. Article 5 is complemented by Article 6 of the CRPD which is a binding equality and non-discrimination article that prohibits discrimination against women and girls with disabilities, obliging States Parties to promote equality of both opportunity and outcomes. Article 6 recognises ‘that women and girls with disabilities are subject to multiple discrimination’,³⁶³ which establishes ‘the first binding intersectionality clause in a human rights treaty.’³⁶⁴

7.48. In its General Comment 3 (Women and Girls with Disabilities), the UN CRPD Committee recognises that the discrimination women and girls with disability experience can constitute ‘structural discrimination’:

Structural, or systemic, discrimination is reflected in hidden or overt patterns of discriminatory institutional behaviour, discriminatory cultural traditions and discriminatory social norms and/or rules. Harmful gender and disability stereotyping, which can lead to such discrimination, is inextricably linked to a lack of policies, regulations and services specifically for women with disabilities. For example, owing to stereotyping based on the intersection of gender and disability, women with disabilities may face barriers when reporting violence, such as disbelief and dismissal by the police, prosecutors and courts. ... The lack of awareness, training and policies to prevent harmful stereotyping of women with disabilities by public officials, be they teachers, health service providers, police officers, prosecutors or judges, and by the public at large can often lead to the violation of rights.³⁶⁵

7.49. General Comment 3 (Women and Girls with Disabilities) specifically recognises that women and girls with disability are more likely to be discriminated against than men and boys with disability and women and girls without disability.³⁶⁶ This General Comment highlights that women and girls with disability experience the ‘same harmful practices’³⁶⁷ committed against women without disability but also experience specific and unique forms of violence. This includes: the absence of free and informed consent and legal compulsory detention and treatment; economic exploitation; violations of sexual and reproductive rights; and forms of violence that constitute torture and ill-treatment, such as forced or coerced sterilisation, the administration of electroshock treatment and the use of chemical, physical or mechanical restraints, and isolation and seclusion.³⁶⁸

7.50. Article 6 is a cross-cutting article that relates to all other articles of the CRPD.³⁶⁹ This means that the issues and concerns of women and girls with disability must be included in all actions to implement the CRPD, including the implementation of ‘positive measures... to ensure that women with disabilities are protected against multiple discrimination and can enjoy human rights and fundamental freedoms on an equal basis with others.’³⁷⁰

7.51. Article 6 ensures that the CRPD is not gender neutral, and this is reinforced by other elements within the CRPD:

- Preamble paragraph (s) states, ‘[e]mphasising the need to incorporate a gender perspective in all efforts to promote the full enjoyment of human rights and fundamental freedoms by persons with disabilities’;
- Article 3(g) contains the principle ‘Equality between men and women’; and
- Specific ‘sex’, ‘gender’ and ‘age’ references are included throughout the CRPD.³⁷¹

7.52. General Comment 3 (Women and Girls with Disabilities) clarifies that Article 6 is a binding non-discrimination and equality provision that unequivocally obligates Governments to outlaw discrimination against women with disability and promotes equality of opportunity and equality of outcomes. In order to combat multiple discrimination against women and girls with disability, States Parties must abolish laws and introduce other laws:

Repealing discriminatory laws, policies and practices that prevent women with disabilities from enjoying all the rights enshrined in the Convention, outlawing gender- and disability-based discrimination and its intersectional

forms, criminalizing sexual violence against girls and women with disabilities, prohibiting all forms of forced sterilization, forced abortion and non-consensual birth control, prohibiting all forms of forced gender- and/or disability-related medical treatment and taking all appropriate legislative steps to protect women with disabilities against discrimination.

Adopting appropriate laws, policies and actions to ensure that the rights of women with disabilities are included in all policies, especially in policies related to women in general and policies on disability.³⁷²

- 7.53. The UN CRPD Committee also emphasises the importance of recognising and addressing stigma and stereotypes pertaining to women with disability, even though they might seem 'benign':

Ensuring the human rights of women requires, first and foremost, a comprehensive understanding of the social structures and power relations that frame laws and policies, as well as of economic and social dynamics, family and community life, and cultural beliefs. Gender stereotypes can limit women's capacity to develop their own abilities, pursue professional careers and make choices about their lives and life plans. Both hostile/negative and seemingly benign stereotypes can be harmful. Harmful gender stereotypes need to be recognized and addressed in order to promote gender equality. The Convention enshrines an obligation to combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age, in all areas of life.³⁷³

- 7.54. The importance of ageism in relation to older women with disability warrants further attention. The Special Rapporteur on Disabilities explains ageism and ableism as follows:

Although ageism and ableism share common roots and consequences, inequality in older age is not the mere result of ableist biases. Ageism – the stereotyping of, and prejudice and discrimination towards, older people and older age – is a distinct form of oppression that affects older persons, including older persons with disabilities. Older persons are often perceived as a burden, dependent, unproductive, undeserving or helpless. While disability is increasingly understood as a social construct, inequalities due to old age are predominantly seen as "natural" or "inevitable." Therefore, older persons with disabilities are discriminated against and disadvantaged not just because they have a disability, but also because of stereotypes about older people.³⁷⁴

- 7.55. She notes that older women with disability are particularly impacted:

Older women with disabilities have consistently worse life prospects and outcomes than older women without disabilities and older men with disabilities. Gender roles and expectations often push these women into economic dependency. As a result, older women with disabilities are considerably poorer; are likely to be subject to violence, abuse and neglect; and have higher chances of facing unmet needs and human rights violations. In addition, older women with disabilities are more likely to be institutionalized or incapacitated owing to the higher life expectancy of women compared with men.³⁷⁵

7.56. The Special Rapporteur on Disabilities identifies a number of human rights challenges affecting older persons with disabilities: ‘stigma and stereotypes; direct and indirect discrimination; denial of autonomy and legal capacity; institutionalization and lack of community support; violence and abuse; and lack of adequate social protection.’³⁷⁶

7.57. A key issue in relation to restrictive practices is the denial of legal capacity in relation to older people with disability:

Given the intersection between disability and age, older persons with disabilities experience an increased risk of limitations on their right to autonomy and on the exercise of their legal capacity. Grounds for the denial of legal capacity are not limited to the existence or perception of an impairment but include other factors such as negative perceptions (e.g. being perceived as “frail and senile”), loss of income and family abandonment. As a result, older persons with disabilities are more likely to be subject to guardianship, institutionalization, home confinement and involuntary treatment than those without disabilities. Persons with dementia in particular have been assumed to possess weak or even no agency. The diagnosis of Alzheimer’s disease or dementia alone is often the justification for the denial of the exercise of rights such as the right to marry or to make a will. Persons with psychosocial disabilities continue to be exposed to forced treatment as they age, with increased vulnerability to guardianship and permanent institutionalization and with less access to alternative mental health services or to social support under the independent living model.

Even when there is no substitute decision-making regime in place, in practice many older persons with disabilities are de facto deprived of their legal capacity. For example, they are often restricted from making autonomous decisions without the consent of their family members, or their informed consent is not sought for medical treatment and social care, including palliative care and end-of-life decisions. The will and preferences of older persons with disabilities regarding daily living arrangements, such as what to eat, what to wear, what time to go to bed or even whether and when to use the bathroom, are sometimes completely disregarded. Older women with disabilities face particular challenges in relation to their legal capacity. They may not have the right to inherit and administer marital property upon the death of their spouse, or their legal capacity is deferred by law or de facto to lawyers or family members without their consent.³⁷⁷

7.58. The Special Rapporteur on Disabilities notes that violence, including physical, psychological and sexual abuse, caregiver neglect and financial exploitation, is another key human rights issue for older persons with disability.³⁷⁸ This is particularly significant in ‘long-term care’ contexts.³⁷⁹

7.59. For women and girls with disability to be treated equally to be treated equally to others, live free from violence and make meaningful choices about their health, where they live, their mobility, their sexual and reproductive activity, and their social, familial and intimate relationships, including living free from the violence of restrictive practices, Australia needs to meet its obligations under Articles 5 and 6 of the CRPD and abolish discriminatory laws that regulate restrictive practices, as well as introducing laws prohibiting and redressing discrimination through restrictive practices.

Freedom from Violence, Abuse, Neglect and Exploitation

7.60. Restrictive practices are a form of violence that violate the right to freedom from violence. In order to prevent this violence, laws that regulate restrictive practices must be abolished and replaced with laws prohibiting and redressing restrictive practices.

7.61. Article 16 of the CRPD requires Governments:

- (a) 'protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects';
- (b) 'prevent all forms of exploitation, violence and abuse';
- (c) 'promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse'; and
- (d) 'put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.'

7.62. Article 6 makes clear the importance of Governments taking a proactive approach to violence prevention and redress, and one that is both attentive to both the gendered dimensions of violence and the specific circumstances and needs of women and girls with disability.

7.63. In relation to women and girls with disability, the UN CRPD Committee has defined violence as being 'interpersonal' or 'institutional and/or structural violence.' The latter is defined as 'any form of structural inequality or institutional discrimination that keeps a woman in a subordinate position, whether physically or ideologically, compared with other people in her family, household or community'.³⁸⁰ According to the UN CRPD Committee, specific examples of violence against women and girls with disability that will violate Article 16 include those relevant to restrictive practices: 'the absence of free and informed consent and legal compulsion'; 'the removal or control of communication aids and the refusal to assist in communicating'; 'the denial of personal mobility and accessibility by, for example, removing or destroying accessibility features such as ramps, assistive devices such as white canes or mobility devices such as wheelchairs'; 'the refusal by caregivers to assist with daily activities such as bathing, menstrual and/or sanitation management, dressing and eating'; 'the withholding of food or water'; and 'the exercise of control, for example by restricting face-to-face or virtual access to family, friends or others'.³⁸¹ Moreover, certain forms of violence (relevant to restrictive practices) can constitute 'cruel, inhuman or degrading treatment or punishment and as breaching a number of international human rights treaties', including:

*... forced, coerced and otherwise involuntary pregnancy or sterilization; any medical procedure or intervention performed without free and informed consent, including procedures and interventions related to contraception and abortion; invasive and irreversible surgical practices such as psychosurgery, female genital mutilation and surgery or treatment performed on intersex children without their informed consent; the administration of electroshock treatment and the use of chemical, physical or mechanical restraints; and isolation or seclusion.*³⁸²

- 7.64. On her mission to Australia, the Special Rapporteur on Violence Against Women has noted the high incidence of women with disability in the criminal justice system, including prison, and the lifelong violence they have experienced:

Criminalized women and girls have exceptionally high levels of mental and cognitive disability compared with the general population. They will have experienced very high rates of sexual and physical violence, most from their childhood or youth, and imprisonment and youth detention exacerbate their trauma.

Women with disabilities represent more than 50 per cent of the female prison population. More than half of all women incarcerated have a diagnosed psychosocial disability and a history of sexual victimization. The rate of incarceration of indigenous women with disabilities is higher than the equivalent figures for men. Indigenous women with disabilities are at risk of being detained, often without conviction, in prisons and forensic psychiatric units throughout Australia, enduring periods of indefinite detention, in some cases for years. Women with psychosocial disabilities and intellectual or learning disabilities are disproportionately classified as high-security prisoners and are more likely to be in high-security facilities than other prisoners.³⁸³

- 7.65. Following its two reviews of Australia in 2013, the UN CRPD Committee expressed concern at ‘reports of high rates of violence perpetrated against women and girls living in institutions and other segregated settings’ and recommended the Australian Government ‘investigate without delay the situations of violence, exploitation and abuse experienced by women and girls with disabilities in institutional settings, and that it take appropriate measures on the findings.’³⁸⁴
- 7.66. In its 2019 review, the UN CRPD Committee expressed concern about the ‘lack of additional oversight, complaint and redress mechanisms needed for persons with disabilities who are not eligible for the National Disability Insurance Scheme, older persons with disabilities and, particularly, women with disabilities’ and the ‘lack of resources and redress mechanisms available to the Royal Commission into Violence, Abuse, Neglect and Exploitation of Persons with Disabilities.’³⁸⁵ It recommended the Australian Government ‘[e]stablish a national accessible oversight, complaint and redress mechanism for persons with disabilities who have experienced violence, abuse, exploitation and neglect in all settings, including all those not eligible for the National Disability Insurance Scheme and, particularly, older women with disabilities’ and ‘[e]nsure adequate resources and a redress mechanism for the Royal Commission into Violence, Abuse, Neglect and Exploitation of Persons with Disabilities.’³⁸⁶
- 7.67. The text and interpretation of this article of the CRPD makes clear that restrictive practices are a form of interpersonal and structural violence and violate the human right to freedom from violence, and thus that this should not be up for debate in the Royal Commission.

Equal Recognition Before The Law

- 7.68. Laws that regulate restrictive practices, including substituted decision-making and compulsory treatment laws, violate the right to equal recognition before the law. Governments are required to abolish discriminatory laws that regulate restrictive practices

and to introduce supported decision-making laws that enable people with disability to have their choices about their bodies and lives legally recognised.

- 7.69. Article 12 of the CRPD provides that Governments: ‘reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law’; ‘shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life’; ‘shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity’; and ‘shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law.’
- 7.70. Article 12 of the CRPD is premised on the CRPD’s general principles, namely: respect for the inherent dignity, individual autonomy (including the freedom to make one’s own choices), and independence of persons; non-discrimination; full and effective participation and inclusion in society; respect for difference and acceptance of persons with disability as part of human diversity and humanity; equality of opportunity; accessibility; equality between men and women; and respect for the evolving capacities of children with disability and respect for the right of children with disability to preserve their identities.
- 7.71. The effect of Article 12 is to recognise universal legal capacity and focus on the provision of support to ensure people with disability have their decisions legally recognised and are not abused in the course of exercising their legal capacity. As explained by the UN CRPD Committee, ‘Article 12 does not permit such discriminatory denial of legal capacity, but, rather, requires that support be provided in the exercise of legal capacity.’³⁸⁷ The right to equal recognition before the law implies that legal capacity is a universal attribute inherent in all persons by virtue of their humanity and must be upheld for persons with disability on an equal basis with others. The UN CRPD Committee acknowledges the problematic nature of ‘mental capacity’, being the basis on which legal capacity is conventionally denied:

*The concept of mental capacity is highly controversial in and of itself. Mental capacity is not, as is commonly presented, an objective, scientific and naturally occurring phenomenon. Mental capacity is contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity.*³⁸⁸

- 7.72. Legal capacity underpins personhood,³⁸⁹ and is central to the realisation of other human rights, as noted by the UN CRPD Committee:

*The right to legal capacity is a threshold right, that is, it is required for the enjoyment of almost all other rights in the Convention, including the right to equality and non-discrimination.*³⁹⁰

- 7.73. The UN CRPD Committee identifies discriminatory laws as central to the denial of legal capacity to people with disability:

States parties must holistically examine all areas of law to ensure that the right of persons with disabilities to legal capacity is not restricted on an unequal basis with others. Historically, persons with disabilities have been denied their right to legal capacity in many areas in a discriminatory manner under

*substitute decision-making regimes such as guardianship, conservatorship and mental health laws that permit forced treatment. These practices must be abolished in order to ensure that full legal capacity is restored to persons with disabilities on an equal basis with others.*³⁹¹

- 7.74. The UN CRPD Committee states that abolishing laws that deny legal capacity is central to realisation of Article 12: ‘In order to fully recognize “universal legal capacity,” whereby all persons, regardless of disability or decision-making skills, inherently possess legal capacity, States parties must abolish denials of legal capacity that are discriminatory on the basis of disability in purpose or effect.’³⁹² Thus, in implementing Article 12, States Parties should:

*Recognize persons with disabilities as persons before the law, having legal personality and legal capacity in all aspects of life, on an equal basis with others. This requires the abolition of substitute decision-making regimes and mechanisms that deny legal capacity and which discriminate in purpose or effect against persons with disabilities.*³⁹³

- 7.75. The UN CRPD Committee has made it clear that Governments’ obligation to replace substitute decision-making regimes by supported decision-making requires both the abolition of substitute decision-making regimes and the development of supported decision-making alternatives.³⁹⁴ Support in the exercise of legal capacity must respect the rights, will and preferences of persons with disability and should never amount to substitute decision-making. Importantly, abolition must occur simultaneously to the introduction and development of supported decision-making:

*States parties’ obligation to replace substitute decision-making regimes by supported decision-making requires both the abolition of substitute decision-making regimes and the development of supported decision-making alternatives. The development of supported decision-making systems in parallel with the maintenance of substitute decision-making regimes is not sufficient to comply with article 12 of the Convention.*³⁹⁵

This is particularly significant in an Australian context, where some States and Territories have had law reform projects on guardianship which have proposed the partial introduction of supported decision-making, while retaining substituted decision-making.³⁹⁶

- 7.76. The UN CRPD Committee recognises forced psychiatric, medical and health treatment as a violation of the right to equal recognition before the law because ‘[t]his practice denies the legal capacity of a person to choose medical treatment.’ Instead, Governments are required to ‘respect the legal capacity of persons with disabilities to make decisions at all times, including in crisis situations’ and provide them with accessible information and supports to make decisions.³⁹⁷ States Parties must abolish policies and legislative provisions that allow or perpetrate forced treatment, as it is an ongoing violation found in mental health laws across the globe, despite empirical evidence indicating its lack of effectiveness and the views of people using mental health systems who have experienced deep pain and trauma as a result of forced treatment. The UN CRPD Committee recommends that States Parties ensure that decisions relating to a person’s physical or mental integrity can only be taken with the free and informed consent of the person concerned.³⁹⁸

- 7.77. In relation to older people with disability, who might be considered to ‘naturally’ relinquish their legal capacity as they age, the Special Rapporteur on Disabilities has stated that:

Having high support needs cannot justify the denial of autonomy and legal capacity. Loss of autonomy is not a natural process, but a social process that results from the failure of society to respect and support the will and preferences of all people. Older persons with disabilities have the right to maintain their legal capacity and to have access to supported decision-making, and their agency needs to be recognized and facilitated. Furthermore, all health and social care services should be based on the free and informed consent of the individual concerned, and all laws that allow involuntary treatment or placement in residential care upon the authorization of third parties, such as family members, or on the basis of an actual or perceived mental health condition or other impairment, should be repealed.³⁹⁹

- 7.78. The UN CRPD Committee recognises that women with disability are subject to multiple and intersectional forms of discrimination and thus are more likely to be denied their right to legal capacity. This has significant impacts on other rights – including the right to maintain sexual and reproductive autonomy, to found a family, to choose where and with whom to live, to be free from violence, to maintain bodily and mental integrity, and to realise their right to work in the open labour market, in work that is freely chosen, and that provides just, favourable conditions of work on an equal basis with others.⁴⁰⁰ It recognises that: ‘[r]estricting or removing legal capacity can facilitate forced interventions, such as sterilization, abortion, contraception, female genital mutilation, surgery or treatment performed on intersex children without their informed consent and forced detention in institutions.’⁴⁰¹ Moreover, it notes that: ‘[f]orced contraception and sterilization can also result in sexual violence without the consequence of pregnancy, especially for women with psychosocial or intellectual disabilities, women in psychiatric or other institutions and women in custody.’⁴⁰²
- 7.79. Many women with disability are not afforded the right to make their own decisions because others determine that they ‘lack capacity’ to do so. Such judgements often lead to substitute decision-making processes whereby others decide, on behalf of a woman or girl, what is in her ‘best interest.’ This is particularly the case for women and girls with intellectual disability – where the diagnosis of intellectual disability is assumed to equate with a lack of capacity to make decisions.⁴⁰³ Substitute decision-making and ‘best interest’ approaches have been thoroughly criticised as fundamentally contravening the CRPD and as intrinsically value-laden.⁴⁰⁴ In practice, the ‘best interest’ approach most often serves the interests of guardians, families, carers and service providers.⁴⁰⁵
- 7.80. Australia continues to maintain that the CRPD ‘[a]llows for fully supported or substituted decision-making where necessary, as a last resort and subject to safeguards.’⁴⁰⁶ This is the basis of the interpretative declaration⁴⁰⁷ that Australia made at the time of ratification of the CRPD in 2008. This position has been maintained over the past 12 years, despite the fact that there has been consistent jurisprudence from the UN CRPD Committee that formal and informal substitute decision-making mechanisms are not compliant with the CRPD, and that these mechanisms must be replaced with fully supported decision-making mechanisms.⁴⁰⁸
- 7.81. In a joint statement, the UN CRPD Committee and the UN CEDAW Committee state that decisions by women with disability about sexual and reproductive health ‘are made freely’ and they are ‘against forced abortion, contraception or sterilization against their will or without their informed consent.’⁴⁰⁹

7.82. Following its two reviews of Australia in 2013 and 2019, the UN CRPD Committee recommended the withdrawal of the interpretative declaration on Article 12 and the replacement of substitute decision-making with supported decision-making.⁴¹⁰ During its 2019 review of Australia, the UN CRPD Committee noted it:

... regretted the continued denial of decision-making capacity to persons with disabilities, which... affected all other areas of life and led to the ongoing practices of forced institutionalisation..., involuntary medical treatments including forced sterilisation and surgery...⁴¹¹

7.83. As discussed in Section 2, in 2014 the ALRC provided its final report from its inquiry into barriers to equal recognition before the law and legal capacity for people with disability.⁴¹² It made 55 recommendations for reform, with its key recommendation focused on the establishment of National Decision-Making Principles and Guidelines to guide reform of Commonwealth, State and Territory laws and legal frameworks. Following its 2019 review, the UN CRPD Committee recommended that Australia implement a ‘nationally consistent supported decision-making framework’, as highlighted by the ALRC. Six years on from the ALRC Report, the Australian Government has still not provided its response to the Report or taken steps to implement the UN CRPD Committee recommendation.

7.84. For women and girls with disability to be treated equally to be treated equally to others, live free from violence and make meaningful choices about their health, where they live, their mobility, their sexual and reproductive activity, and their social, familial and intimate relationships, including living free from the violence of restrictive practices, Australia needs to replace substitute decision-making with supported decision-making that respects the rights, will and preferences of all women with disability. Abolition of laws regulating restrictive practices should not be up for debate in the Royal Commission.

7.85. While it is recognised that Australia has an interpretive declaration in relation to Article 12, this does not prevent the Royal Commission from:

- (a) making recommendations the Australian Government and State and Territory Governments abolish substituted decision-making and compulsory treatment laws on the understanding restrictive practices in general violate the right to legal capacity; and
- (b) recommending the Australian Government withdraw its interpretive declaration so that it assumes a formal obligation under the CRPD to take such action (though absence of such formal obligation does not prevent abolition of laws – there is much legislative reform that takes place in the absence of specific human rights obligations).

Liberty

7.86. Depriving people with disability of their liberty through restrictive practices violates the right to liberty on an equal basis with others. This is either on the basis that the restrictive practices are unlawful, as there is no legal authority pursuant to existing regulatory frameworks, or, if there is legal authority, the lawfulness is justified by disability.

7.87. Article 14 of the CRPD provides that Governments shall ensure that persons with disabilities, ‘on an equal basis with others’, ‘enjoy the right to liberty and security of person’ and ‘are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.’

7.88. This Article makes clear that Governments must ensure women and girls with disability are not deprived of their liberty through restrictive practices if this is done on the basis of their disability.

7.89. The UN CRPD Committee, in summarising its jurisprudence on Article 14, has stated that it requires ‘absolute prohibition of detention on the basis of disability.’ It has also stated that ‘[m]ental health laws that authorize detention of persons with disabilities based on the alleged danger of persons for themselves or for others’ and ‘declarations of unfitness to stand trial and the detention of persons based on that declaration’ are contrary to Article 14.⁴¹³

7.90. In its General Comment 3 (Women and Girls with Disabilities), the UN CRPD Committee has stated that:

Violations relating to deprivation of liberty disproportionately affect women with intellectual or psychosocial disabilities and those in institutional settings. Those deprived of their liberty in places such as psychiatric institutions, on the basis of actual or perceived impairment, are subject to higher levels of violence, as well as to cruel, inhuman or degrading treatment or punishment and are segregated and exposed to the risk of sexual violence and trafficking within care and special education institutions. Violence against women with disabilities in institutions includes: involuntary undressing by male staff against the will of the woman concerned; forced administration of psychiatric medication; and overmedication, which can reduce the ability to describe and/or remember sexual violence. Perpetrators may act with impunity because they perceive little risk of discovery or punishment given that access to judicial remedies is severely restricted, and women with disabilities subjected to such violence are unlikely to be able to access helplines or other forms of support to report such violations.⁴¹⁴

7.91. Following its periodic review of Australia in 2013, the UN CRPD Committee recommended the Australian Government ‘repeal all legislation that authorizes medical intervention without the free and informed consent of the persons with disabilities concerned, committal of individuals to detention in mental health facilities, or imposition of compulsory treatment, either in institutions or in the community, by means of Community Treatment Orders.’⁴¹⁵ It also recommended ending incarceration in prison of un-convicted people with disability, particularly First Nations people with disability, and ‘review its laws that allow for the deprivation of liberty on the basis of disability, including psychosocial or intellectual disabilities, and repeal provisions that authorize involuntary internment linked to an apparent or diagnosed disability.’⁴¹⁶

7.92. In its subsequent 2019 report on its second and third reviews of Australia, the UN CRPD Committee expressed concern about: ‘[l]egislative frameworks, policies and practices that result in the arbitrary and indefinite detention and forced treatment of persons with disabilities, and that such frameworks, policies and practices disproportionately affect Aboriginal and Torres Strait Islander persons with disabilities and persons with intellectual or psychosocial disabilities.’⁴¹⁷ The Committee recommended the Australian Government ‘[r]epeal any law or policy and cease any practice or custom that enables the deprivation of liberty on the basis of impairment and that enables forced medical interventions on persons with disabilities, particularly Aboriginal and Torres Strait Islander persons with disabilities.’⁴¹⁸

7.93. For women and girls with disability to be treated equally to be treated equally to others, live free from violence and make meaningful choices about their health, where they live, their mobility, their sexual and reproductive activity, and their social, familial and intimate relationships, they need to be free from restrictive practices that deprive them of their liberty and keep them segregated and isolated from the community. Australia needs to prevent unlawful restrictive practices and abolish laws regulating restrictive practices.

Personal Integrity

7.94. Restrictive practices intervene in the bodies and minds of people with disability, violating their right to personal integrity.

7.95. Article 17 provides: '[e]very person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.'

7.96. The UN CRPD Committee has stated that '[w]omen with disabilities are more likely to be subjected to forced interventions than are women in general and men with disabilities' and these interventions 'are wrongfully justified by theories of incapacity and therapeutic necessity, are legitimized under national laws and may enjoy wide public support for being in the alleged best interest of the person concerned.' However, it states that such forced interventions 'violate the right to personal integrity.'⁴¹⁹

7.97. Following its two reviews of Australia in 2013, the UN CRPD Committee urged the Australian Government 'to adopt uniform national legislation prohibiting the sterilization of boys and girls with disabilities, and adults with disabilities, in the absence of their prior, fully informed and free consent.'⁴²⁰

7.98. In its subsequent 2019 review, the UN CRPD Committee expressed concern about the legal non-consensual sterilisation, abortion and contraception of women and girls with disability and non-consensual surgery on intersex infants and children.⁴²¹ It recommended the Australian Government review and amend laws to prohibit these practices.⁴²² It also recommended the Australian Government '[p]rohibit the use of non-consensual electroconvulsive therapy on the basis of any form of impairment.'⁴²³

7.99. For women and girls with disability to be treated equally to be treated equally to others, live free from violence and make meaningful choices about their health, where they live, their mobility, their sexual and reproductive activity, and their social, familial and intimate relationships, including living free from the violence of restrictive practices, they need to be free from restrictive practices that violate their personal integrity. Australia needs to introduce laws to prohibit restrictive practices.

7.100. While it is recognised that Australia has an interpretive declaration in relation to Article 17, this does not prevent the Royal Commission from: (a) making recommendations the Australian Government and State and Territory Governments abolish laws on restrictive practices that deprive people with disability of their liberty on the understanding restrictive practices in general violate the right to legal capacity; and (b) recommending the Australian Government withdraw its interpretive declaration so that it assumes a formal obligation under the CRPD to take such action (though absence of such formal obligation does not prevent abolition of laws – there is much legislative reform that takes place in the absence of specific human rights obligations).

Freedom from Torture

- 7.101. Restrictive practices can violate the right to freedom from torture, because law and the State regulate these interventions, along with cruel, inhuman and degrading treatment, to the extent they inflict severe pain and suffering.
- 7.102. Article 15 provides that '[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment' and that 'States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.'
- 7.103. The Special Rapporteur on Disabilities provides examples of torture and cruel, inhuman and degrading treatment, including: 'forced sterilization, contraception and abortion; forced medical procedures or interventions aimed at correcting or alleviating a disability, including invasive and irreversible surgeries, electroconvulsive therapy and the administration of psychotropic medication; the use of chemical, physical or mechanical restraints; and isolation or seclusion.'⁴²⁴ All of these examples constitute restrictive practices.
- 7.104. The Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Special Rapporteur on Torture) states in the context of persons with psychosocial disability that 'both prolonged seclusion and restraint may constitute torture and ill-treatment.'⁴²⁵ He has also stated that solitary confinement 'of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment.'⁴²⁶ And, that restraint 'for even a short period of time may constitute torture and ill-treatment.'⁴²⁷ The Special Rapporteur on Torture also identifies 'involuntary treatment and other psychiatric interventions in health-care facilities are forms of torture and ill-treatment', 'to the extent that they inflict severe pain and suffering' even when done pursuant to law and on the basis of best interests.⁴²⁸
- 7.105. The Special Rapporteur on Torture has also described as torture or ill-treatment 'medical treatments of an intrusive and irreversible nature, when lacking a therapeutic purpose [and] when enforced or administered without the free and informed consent of the person concerned', 'notwithstanding claims of good intentions or medical necessity.'⁴²⁹
- 7.106. The Special Rapporteur on Torture calls for an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including: 'the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics';⁴³⁰ 'all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, ... in all places of deprivation of liberty, including in psychiatric and social care institutions';⁴³¹ and the 'institutionalisation of persons with disabilities on the grounds of their disability without their free and informed consent.'⁴³²
- 7.107. The prohibition of torture is an 'absolute and non-derogable human right', such that scarce financial resources cannot justify postponement of its implementation.⁴³³ Thus, understanding restrictive practices as torture gives rise to a significant expectation that Australia will act to prevent and redress these practices. The Special Rapporteur on Torture explains this distinction from other human rights in the context of healthcare:

The right to an adequate standard of health care ("right to health") determines the States' obligations towards persons suffering from illness. In turn, the absolute and non-derogable nature of the right to protection from torture

and ill-treatment establishes objective restrictions on certain therapies. In the context of health-related abuses, the focus on the prohibition of torture strengthens the call for accountability and strikes a proper balance between individual freedom and dignity and public health concerns. In that fashion, attention to the torture framework ensures that system inadequacies, lack of resources or services will not justify ill-treatment. Although resource constraints may justify only partial fulfilment of some aspects of the right to health, a State cannot justify its non-compliance with core obligations, such as the absolute prohibition of torture, under any circumstances.⁴³⁴

- 7.108. Furthermore, conduct that amounts to torture or ill-treatment gives rise to a duty to provide remedy and reparation.⁴³⁵ The right to redress includes restitution, compensation, rehabilitation, satisfaction, guarantees of non-repetition and the right to truth.⁴³⁶
- 7.109. Torture specifically extends to non-consensual and coercive sterilisation and abortion. The Special Rapporteur on Torture has stated ‘[f]orced sterilization is an act of violence, a form of social control, and a violation of the right to be free from torture and other cruel, inhuman, or degrading treatment or punishment.’⁴³⁷
- 7.110. The Australian Government recently ratified the OPCAT. This requires the Australian Government to introduce a system of NPM monitoring in ‘places of detention.’ Article 4 of OPCAT defines places of detention as places ‘where persons are or may be deprived of their liberty.’⁴³⁸ Concerns have been raised that the Australian Government is not including disability and aged care sites of confinement in the scope of its NPM monitoring. There are also concerns that ‘torture’ in places of detention will not include non-consensual and coercive interventions in people with disability that can be framed as ‘therapeutic’ and ‘supportive.’⁴³⁹
- 7.111. Following its two reviews of Australia in 2013, the UN CRPD Committee recommended the Australian Government take immediate steps to end the use of restrictive practices, including in schools, mental health facilities and hospitals and establish ‘an independent national preventive mechanism to monitor places of detention – such as mental health facilities, special schools, hospitals, disability justice centres and prisons.’⁴⁴⁰
- 7.112. In its subsequent 2019 review, the UN CRPD Committee expressed serious concern about: ‘[l]egislation, policies and practices that permit the use of psychotropic medications, physical restraints and seclusion under the guise of “behaviour modification” and restrictive practices against persons with disabilities, including children, in any setting, including in justice, education, health, psychosocial and aged care facilities.’⁴⁴¹ It recommended the Australian Government:

Establish a nationally consistent legislative and administrative framework for the protection of all persons with disabilities, including children, from the use of psychotropic medications, physical restraints and seclusion under the guise of “behaviour modification” and the elimination of restrictive practices, including corporal punishment, in all settings, including the home.⁴⁴²

It also recommended the Australian Government ensure people with disability cannot be detained in solitary confinement.

7.113. For women and girls with disability to be treated equally to be treated equally to others, live free from violence and make meaningful choices about their health, where they live, their mobility, their sexual and reproductive activity, and their social, familial and intimate relationships, including living free from the violence of restrictive practices, they need to be free from restrictive practices that give rise to torture and other ill-treatment. Australia needs to immediately introduce laws to prohibit and redress restrictive practices that amount to torture and other ill-treatment.

Living Independently and Being Included in the Community

7.114. Restrictive practices that result in institutionalisation and/or deny people with disability the opportunity to live independently and be included in the community violate Article 19 of the CRPD. Given the routine use of restrictive practices is a key dynamic in warehousing by disability services which we discussed in Section 5, deinstitutionalisation would remove one of the key contexts and drivers for use of restrictive practices.

7.115. Article 19 of the CRPD recognises the equal right of people with disability to live in the community, to be fully included and to participate in community life, with choices equal to others. It means that people with disability have the same right as everyone else to exercise ‘freedom of choice and control over decisions affecting one’s life with the maximum level of self-determination and interdependence within society.’⁴⁴³

7.116. CRPD General Comment 5 (Living Independently and Being Included in the Community) makes clear that Article 19 is about autonomy and individual choice, liberty and security, freedom of movement and being a full participating member of the community on an equal basis with others. An examination of restrictive practices must be considered within this broader human rights context.

7.117. The UN CRPD Committee states that institutionalisation is inherently discriminatory:

*Institutionalization is discriminatory as it demonstrates a failure to create support and services in the community for persons with disabilities, who are forced to relinquish their participation in community life to receive treatment. The institutionalization of persons with disabilities as a condition to receive public sector mental health services constitutes differential treatment on the basis of disability and, as such, is discriminatory.*⁴⁴⁴

The UN CRPD Committee clarifies that any institutional form of support services which segregates and limits personal autonomy is not permitted by Article 19(b).

7.118. The Special Rapporteur on Disabilities notes the greater use of institutionalisation in relation to older persons with disabilities, particularly at a time when ‘younger persons with disabilities are increasingly encouraged and provided with support to live independently.’⁴⁴⁵ The Special Rapporteur on Disabilities sees the lack of support services in the community for older people with disability as a key driver of institutionalisation, including by reason of age limits on accessing disability supports.⁴⁴⁶ She states that institutionalisation should not be the solution to an absence of care in the community and that ‘States need to transform their institutional forms of care for older persons with disabilities and to provide support and services within the community.’⁴⁴⁷

7.119. Following deinstitutionalisation (i.e. closure of largescale institutions), groups homes and supported accommodation became an increasingly significant form of housing. The Royal Commission has acknowledged the closed and segregated nature of these alternatives forms of housing. However, the UN CRPD Committee has explicitly stated that these forms of accommodation do not meet the right in Article 19:

Neither large-scale institutions with more than a hundred residents nor smaller group homes with five to eight individuals, nor even individual homes can be called independent living arrangements if they have other defining elements of institutions or institutionalization. Although institutionalized settings can differ in size, name and set-up, there are certain defining elements, such as obligatory sharing of assistants with others and no or limited influence over whom one has to accept assistance from; isolation and segregation from independent life within the community; lack of control over day-to-day decisions; lack of choice over whom to live with; rigidity of routine irrespective of personal will and preferences; identical activities in the same place for a group of persons under a certain authority; a paternalistic approach in service provision; supervision of living arrangements; and usually also a disproportion in the number of persons with disabilities living in the same environment. Institutional settings may offer persons with disabilities a certain degree of choice and control; however, these choices are limited to specific areas of life and do not change the segregating character of institutions.⁴⁴⁸

7.120. The UN CRPD Committee explicitly and unequivocally states that Article 19 requires Governments to ‘to phase out institutionalisation’⁴⁴⁹ through ‘adopt[ing] clear and targeted strategies for deinstitutionalisation, with specific time frames and adequate budgets, in order to eliminate all forms of isolation, segregation and institutionalization of persons with disabilities.’⁴⁵⁰

7.121. The UN CRPD Committee recognises the centrality of Article 19 to preventing deprivation of liberty on the basis of disability.⁴⁵¹ This is because deinstitutionalisation and supporting individuals to live in the community will remove many of the sites of confinement in which people are deprived of their liberty.

7.122. The UN CRPD Committee has acknowledged that women and girls with disability are particularly disadvantaged in relation to institutionalisation:

Often, women and girls with disabilities (art. 6) are more excluded and isolated and face more restrictions regarding their place of residence as well as their living arrangements owing to paternalistic stereotyping and patriarchal social patterns that discriminate against women in society. Women and girls with disabilities also experience gender-based, multiple and intersectional discrimination, greater risk of institutionalization and violence, including sexual violence, abuse and harassment. ... Therefore, when implementing the right to live independently and be included in the community, particular attention should be paid to gender equality, the elimination of gender-based discrimination and patriarchal social patterns.⁴⁵²

7.123. In CRPD General Comment 5 (Living Independently and Being Included in the Community), the UN CRPD Committee recognises the inherent risk to women and girls with disability in segregated settings:

*Since institutions tend to isolate those who reside within them from the rest of the community, institutionalised women and girls with disabilities are further susceptible to gender-based violence, including forced sterilization, sexual and physical abuse, emotional abuse and further isolation. They also face increased barriers to reporting such violence. It is imperative that States include these issues in their monitoring of institutions and ensure access to redress for women with disabilities who are exposed to gender-based violence in institutions.*⁴⁵³

- 7.124. Following its periodic review of Australia in 2013, the UN CRPD Committee expressed concern ‘that despite the policy to close large residential centres, new initiatives replicate institutional living arrangements, and many persons with disabilities are still obliged to live in residential institutions in order to receive disability support.’ It thus encouraged the Australian Government to ‘develop and implement a national framework for the closure of residential institutions and to allocate the resources necessary for support services that would enable persons with disabilities to live in their communities’ and recommended it ‘take immediate action to ensure that persons with disabilities have a free choice as to where and with whom they want to live, and that they are eligible to receive the necessary support regardless of their place of residence.’⁴⁵⁴
- 7.125. In its subsequent 2019 review, the UN CRPD Committee recommended the Australian Government: ‘[d]evelop a national framework aimed at closing all disability-specific residential institutions and preventing trans-institutionalisation, including by addressing how persons with disabilities not eligible for the National Disability Insurance Scheme can be supported to transition from living in an institution to living independently in the community.’⁴⁵⁵
- 7.126. For women and girls with disability to be treated equally to others, live free from violence and make meaningful choices about their health, where they live, their mobility, their sexual and reproductive activity, and their social, familial and intimate relationships, including living free from the violence of restrictive practices, all institutions need to be closed. Further, women must be given the support and resources to choose where they live, and the support and resources to live where they choose, and restrictive practices that deny women the opportunity to live where they choose must be abolished.



8 RESPONSES TO RESTRICTIVE PRACTICES ISSUES PAPER

8. RESPONSES TO RESTRICTIVE PRACTICES ISSUES PAPER

- 8.1. This section provides brief responses to questions in the Restrictive Practices Issues Paper. These responses are informed by the more detailed discussion and analysis in Sections 4, 5, 6 and 7 of this submission.
- 8.2. At the core of our responses to Restrictive Practices Issues Paper questions – and of our submission as a whole – is WWDA’s position that restrictive practices per se, **whatever context, setting and reason for use** are violent and are in violation of human rights. Their use must be prohibited and redressed, and legal frameworks for substitute decision-making and compulsory treatment authorising restrictive practices must be abolished. This has been the position of WWDA for a number of years, and we continue to hold this position. Regulation, exceptions, minimisation, limitations, reductions etc. are not enough. Ultimately, such approaches still allow restrictive practices – and violence – to continue to be perpetrated on people with disability. Therefore, many of our responses to the Restrictive Practices Issues Paper are intentionally brief, because in light of WWDA’s approach to restrictive practices the questions asked are misdirected in not being focused on the ultimate aims of prohibition and redress.
- 8.3. The questions asked in the Restrictive Practices Issues Paper inform the responses received which in turn informs the findings and recommendations made by the Royal Commission. The Royal Commission’s structuring of its Restrictive Practices Issues Paper by reference to a set of questions might be viewed as opening up discussions to a wide variety of topics, and as inviting diverse and provocative perspectives. However, the scope of these questions can also have the counter-effect of limiting the scope of responses and of justifying the current status quo if questions are narrowly framed. In particular, we note the absence in the Restrictive Practices Issues Paper of any questions directed towards:
- (a) prohibition and redress of restrictive practices,
 - (b) abolition of the legal frameworks regulating restrictive practices, and
 - (c) the specific issues facing use and legality of restrictive practices in relation to women and girls with disability.

While we have woven discussion of these issues into our submission and our responses to the questions, we raise these issues here in order to request that the Royal Commission explicitly address these omitted aspects of restrictive practices in later issues papers and public hearings.

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

- 8.4. Restrictive practices include interventions that are exclusively or primarily perpetrated on women and girls with disability. These include: non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion, forced child removal and denial of support for sexual activity and intimate relationships.

- 8.5. Restrictive practices also includes non-consensual and coercive psychotropic medication and non-consensual and coercive menstrual suppression and contraception even when these are prescribed for treatment of a medical condition rather than influencing behaviour.
- 8.6. Restrictive practices are a form of violence against women and girls with disability. On one level, restrictive practices are a form of interpersonal violence because they are non-consensual and coercive interventions perpetrated by one individual onto another. But, beyond this, restrictive practices are a form of gendered ableist legal violence against women and girls with disability.
- 8.7. Restrictive practices are human rights violations. They violate rights of people with disability to equality and non-discrimination, legal capacity, freedom from violence and torture, personal integrity, liberty, and independent living and community inclusion as provided by the CRPD, and other international human rights instruments.
- 8.8. On the basis of our approach to restrictive practices, we have identified five considerations in relation to whether the explanation of restrictive practices in the Restrictive Practices Issues Paper needs to change:
- First, the explanation of restrictive practices in the Restrictive Practices Issues Paper needs to change in order to be explicit and unequivocal about restrictive practices as non-consensual and coercive. The Restrictive Practices Issues Paper prepared by the Royal Commission is silent on the non-consensual and coercive nature of restrictive practices and is ambivalent about whether restrictive practices are violent and violate human rights. This ambivalence was also reflected in the psychotropic medications hearing, and thus signals a worrying trend towards a very limited and potentially ableist understanding of violence.
 - Second, the explanation of restrictive practices needs to explicitly identify restrictive practices as violence that is currently lawful on the basis of disability.
 - Third, the Royal Commission might consider the utility of ‘restrictive practices’ as an organising concept for exploring violence against people with disability, instead of using terms such as violence/assault/detention and other terms that more explicitly and accessibly describe these interventions. Use of the term ‘restrictive practices’ might sustain societal acceptance of these practices against people with disability as somehow less than violence. ‘Restrictive practices’ is a term not widely known in the general community or in the legal and human rights communities. Further, the enduring medicalised notions of people with disability as having aberrant, abnormal or risky behaviour mean that interventions done in the name of ‘restrictive practices’ can be associated with protection and control and are thus perceived as non-violent. In short, ‘restrictive practices’ might ‘detoxify’⁴⁵⁶ the violence of the interventions done in its name.
 - Fourth, the explanation of restrictive practices in the Restrictive Practices Issues Paper needs to explicitly mention restrictive practices specifically experienced by women and girls with disability, including non-consensual and coercive sterilisation, menstrual suppression, contraception, abortion, forced child removal, and denial of support for sexual activity and intimate relationships.
 - Fifth, the definition of restrictive practices should not be limited to interventions for the purpose of responding to behaviour, and should extend to interventions for the purpose of treatment of medical conditions. As we have explained in Sections 5 and 6, the existing behaviour/medical division is problematic because it is socially and economically contingent and is ableist and gendered. the explanation of restrictive

practices in the Restrictive Practices Issues Paper needs to explicitly mention psychotropic medication even when this is prescribed for medical treatment rather than influencing behaviour.

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

- 8.9. Restrictive practices applied to women and girls with disability include long-term prescribing of psychotropic medication (often coupled with threats or incentives to ensure compliance with medication), ECT, detention in locked rooms or accommodation, removing or immobilising mobility aids, not being provided with services and supports to enable mobility around and beyond accommodation, and locking fridges and cupboards to prevent access to food.
- 8.10. Restrictive practices applied to women and girls with disability also extend to practices that are inextricably related to embodied and social experiences that are gendered as female – such as menstruation, sexual assault and domestic violence victimisation, sexuality and intimacy, reproduction, mothering, menopause, and gynaecological cancers. These restrictive practices include: non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion, forced child removal and denial of support for sexual activity and intimate relationships.
- 8.11. Unfortunately, it is not possible to answer whether certain types of restrictive practices are more common than others, because there is an absence of publicly available data on the use of restrictive practices, including data that is disaggregated by gender. There is also an absence of publicly available data on court and tribunal decision-making relating to substitute decision-making, including data that is disaggregated by gender. However, we do note that restrictive practices are systemically routinely used in disability and aged care services, and this is supported by the current legality of restrictive practices, including in the regulatory frameworks of disability and aged care services.

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

- 8.12. Unfortunately, it is not possible to answer how often people with disability are subjected to restrictive practices, because there is an absence of publicly available data on the use of restrictive practices, including data that is disaggregated by gender. There is also an absence of publicly available data from courts and tribunals on appointment of substitute decision-makers to consent to restrictive practices and publicly available data from public guardianship organisations on the authorisation of restrictive practices, including data that is disaggregated by gender. However, we do note that restrictive practices are systemically routinely used in disability and aged care services, and this is supported by the current legality of restrictive practices, including in the regulatory frameworks of disability and aged care services.
- 8.13. Regardless, we caution assessing the extent of the violence of restrictive practices by reference to a quantitative evaluation of the frequency of their use as an isolated phenomenon. It is important to understand subjection to restrictive practices as one

dimension of longer-term structural violence experienced by people with disability, including women and girls with disability. Methodologically, the Royal Commission might explore particular embodied individuals' entire life courses in order to understand the cumulative and interrelatedness of experiences of violence across one's life and how this shapes the overall possibilities for flourishing. It would also allow the Royal Commission to explore how different systems' logics, practices and legal frameworks interlock to hold certain disabled populations in a way of life where violence is naturalised.

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

Question 5: Why are restrictive practices used?

- 8.14. Restrictive practices are used for organisational convenience, efficiency, legitimisation, risk management and profit or financial gain. Restrictive practices are used to control, exclude, segregate and isolate people with disability. Restrictive practices are used to enforce ableist, racist and sexist norms of behaviour, appearance and identity. Yet, they also have a productive dimension. They can also be used to extract profit from the bodies of people with disability because restrictive practices can enhance the economic efficiency of care provision and thus maximise the profit extracted from a disabled body in care.
- 8.15. Restrictive practices are also used because they are legal. Legal doctrine permits restrictive practices per se, and courts and tribunals enable perpetration of restrictive practices in relation to specific individuals. If the Royal Commission wants to end violence against people with disability through restrictive practices, it needs to abolish substitute decision-making and compulsory treatment laws that currently enable restrictive practices.
- 8.16. The conventional rationale for using restrictive practices – responding to 'challenging behaviour' or 'behaviours of concern' – individualises, pathologises and neutralises disabled people's legitimate responses to their living arrangements and experiences of oppression, structural discrimination and violence.
- 8.17. Restrictive practices are used in group homes, family homes, aged care facilities, schools, day programs, segregated employment (ADEs), segregated and general school settings, prisons and mental health facilities. However, they are not limited to certain settings. For some individuals, restrictive practices travel with them via guardianship orders, community treatment orders, community forensic mental health and court diversion orders. In this way, use of restrictive practices can have the effect of transforming places in the general community (such as a family home or group home which are otherwise unlocked to other residents) into segregated and closed settings.
- 8.18. Non-consensual and coercive sterilisation, menstrual suppression, contraception, abortion and denial of support for sexual activity and intimate relationships are used in circumstances where service providers and family members have stigma towards menstrual blood and towards women and girls with disability as sexual, reproductive and lovable beings. Yet, it is not only about stigma. It is also important to explore how these forms of restrictive practices are used due to economic drivers of services maximising efficiency and work health and safety risk management. Profiting from women and girls' bodies through provision of disability support services can result in their embodied and social gendered experiences being judged as too costly, labour-intensive and organisationally risky.

Question 6: What are the effects of restrictive practices?

- 8.19. The effects of restrictive practices include physical and psychological injury, long term trauma, long term physical health problems and premature death. At an individual level, they have the effect of contributing to isolation, segregation and confinement of people with disability. At a structural level, they contribute to discrimination, segregation, invisibility, oppression and dehumanisation of people with disability.
- 8.20. Restrictive practices violate various human rights in the CRPD and other international human rights instruments, including rights to equality and non-discrimination, freedom from violence and torture, legal capacity, personal integrity, liberty, and independent living and community inclusion.
- 8.21. The effects of sterilisation, menstrual suppression, contraception, abortion, forced child removal and denial of support for sexual activity and intimate relationships for women and girls with disability are varied. They include the inability to have children and parent these children, the inability to experience menstruation, the inability to experience sexual pleasure and intimacy, the inability to love and be loved by an intimate partner or offspring child, physical health problems such as osteoporosis, early menopause and some gynaecological cancers, and long-term trauma. The use of restrictive practices on women and girls with disability can mask violence, neglect, health problems, menopause and pain, all of which can perpetuate injustice and impunity, increase physical and psychological suffering, and cause premature death.
- 8.22. The severe and long-term effects caused by restrictive practices necessitate redress, both redress for individual victims and structural redress that engages the community and is directed towards the transformation of systems and cultures that sustain this violence. Consideration of redress should extend to historical instances of violence against people with disability as a vital component of transforming systems, structures and cultures of violence against people with disability. While the Royal Commission in the DRC Interim Report acknowledges histories of violence,⁴⁵⁷ it is unclear whether it will be exploring historical violence in any depth, including in the context of redress.
- 8.23. At the same time as causing such severe impacts on people with disability, restrictive practices can also have the effect of increased profits for disability services. Thus, any consideration of preventing and redressing use of restrictive practices must extend to a comprehensive consideration of the economic dynamics of this violence.

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

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

- 8.24. The use of restrictive practices is different in relation to women and girls with disability, in terms of the forms, justifications and effects of restrictive practices. Restrictive practices applied to women and girls with disability also extend to practices that are inextricably related to embodied and social experiences that are gendered as female – such as menstruation, sexual assault and domestic violence victimisation, female sexuality and

intimacy, reproduction, mothering, menopause, and gynaecological cancers. These restrictive practices include: non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion, forced child removal and denial of support for sexual activity and intimate relationships.

- 8.25. However, in considering the experiences of women and girls with disability, it is also important to be mindful that there is no singular experience characterising this group, and there is diversity of experience.
- 8.26. Unfortunately, it is not possible to answer if women and girls with disability are subjected to a higher frequency of restrictive practices, because there is an absence of publicly available data on the use of restrictive practices, including data that is disaggregated by gender. There is also an absence of publicly available data on court and tribunal decision-making relating to substitute decision-making, including data that is disaggregated by gender. The Royal Commission must seek out this data from all relevant authorities so this data can inform its work and, where data collection is not taking place (or is not sufficiently disaggregated) the Royal Commission must make recommendations requiring data collection and public access to data.

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

- 8.27. Use of restrictive practices leads to further violence, abuse, neglect and exploitation because it results in isolation, segregation and confinement of individuals. These conditions are known to increase perpetration of violence, and to result in a lack of transparency and accountability.
- 8.28. Use of restrictive practices as a response to ‘challenging behaviour’ or ‘behaviours of concern’ can also conceal the perpetration of violence and mask trauma and distress from previous experiences of violence. This means violence goes undetected and perpetrators are not held accountable, thus building a culture where violence can flourish. This is particularly significant in segregated and closed settings where unlawful violence occurs (e.g. group homes, prisons, inpatient mental health facilities, RACFs).
- 8.29. Use of restrictive practices in ADEs contributes to the economic exploitation of people with disability ADEs, and gives rise to the possibility they contribute to servitude and forced labour in ADEs.

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

A: Are there any gaps in the current approaches?

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

- 8.30. The use of restrictive practices is currently legal. This means that law allows violence to be perpetrated on people with disability through use of restrictive practices.

- 8.31. If the Royal Commission wants to end all forms of violence against people with disability, including through restrictive practices, it needs to abolish substitute decision-making and compulsory treatment laws that enable restrictive practices. Importantly, this must extend beyond abolishing legislative frameworks and address the foundational role of the common law doctrine of *parens patriae*.
- 8.32. Current legal approaches to restrictive practices are ineffective because they regulate rather than prohibit restrictive practices. The fundamental gap in this current approach is prohibition of restrictive practices and abolition of substitute decision-making and compulsory treatment laws. The impact of this gap is that violence through restrictive practices is permitted by law and incapable of being redressed. Moreover, the absorption of oversight/regulation of restrictive practices into bodies tasked with safety and violence prevention in disability and aged care services is very fraught because it contributes to the ambivalence towards restrictive practices as violence.
- 8.33. There are gaps in the laws and justice processes for removing substitute decision-making orders and challenge the legality of restrictive practices. It is widely known in the disability community that guardianship orders and financial management orders are much harder to remove than it is to have them made, and that there is no access to social and other support to develop individual's decision-making and life skills in support of the removal of orders.
- 8.34. There is also a legal gap in terms of redressing use of restrictive practices. This gap arises because restrictive practices are either permitted by law, or they are technically illegal but there are no accessible pathways to seek redress.
- 8.35. A further gap is the failure of Australian and State and Territory independent oversight bodies under the OPCAT to categorise RACFs and disability residential facilities for people with disability as 'places of detention' under the OPCAT, and monitor these accordingly.
- 8.36. Restrictive practices violate various human rights in the CRPD and other international human rights instruments, including rights to equality and non-discrimination, freedom from violence and torture, legal capacity, personal integrity, liberty, and independent living and community inclusion.

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

A: What rules and safeguards should be applied?

B: Should the same rules apply to all people?

- 8.37. It is unclear why this question is being asked by the Royal Commission, if restrictive practices are understood as violence (e.g. it would not be conceivable to ask 'in what circumstances may domestic violence or sexual assault be needed?').
- 8.38. This question's underlying assumption that restrictive practices are per se necessary might itself speak to the failure to unseat assumptions in legal and justice systems, health and medical systems, disability service provision and law reform processes of the pervasiveness and depth of the violability, ungrievability and need to control people with disability in our society.

- 8.39. Restrictive practices are a form of violence and discrimination, and as such are never necessary and should be prohibited.
- 8.40. Non-consensual and coercive sterilisation, menstrual suppression, contraception and abortion a form of violence and discrimination, and as such are never necessary and should be prohibited.

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

A: What needs to change in laws and policies?

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

C: What are the barriers to this change?

- 8.41. It is unclear why this question is being asked by the Royal Commission, if restrictive practices are understood as violence. This runs counter to the Royal Commission's Term of Reference that focuses on preventing violence:

*... what governments, institutions and the community should do to prevent, and better protect, people with disability from experiencing violence, abuse, neglect and exploitation, having regard to the extent of violence, abuse, neglect and exploitation experienced by people with disability in all settings and contexts.*⁴⁵⁸

- 8.42. Restrictive practices are currently legal. Legal doctrine permits restrictive practices per se, and courts and tribunals enable perpetration of restrictive practices in relation to specific individuals. If the Royal Commission wants to end violence against people with disability through restrictive practices, it needs to abolish substitute decision-making and compulsory treatment laws that enable restrictive practices.
- 8.43. To frame the issue in terms of how to 'avoid' or 'minimise' restrictive practices (rather than prohibition and abolition) implicitly assumes the continued existence and use of restrictive practices, albeit potentially reduced. As Roper et al (all of whom have lived experience of Australian and New Zealand mental health systems) state '[t]he discourse of reducing does not fundamentally challenge people's beliefs about what is possible in the real world. It instead still presumes the "necessary evil" discourse, signalling a failure of imagination and leadership guaranteeing services will never fully eliminate such practices.'⁴⁵⁹
- 8.44. The language of 'reduction and elimination' is also vague in terms of the role of law. To eliminate through reduction suggests law will continue to allow restrictive practices, and elimination instead relies on organisational and professional behavioural change to stop usage. Retaining laws that allow restrictive practices keeps in place the structural legal dynamics that allow this to occur. Furthermore, as McSherry and Maker note, 'restrictive practices have proved difficult to eliminate – or in many cases meaningfully reduce – despite the introduction of one or more of these models of regulation. ... While regulation can protect against the arbitrary use of these practices and specify procedural safeguards, it also arguably normalises their use and necessitates the assessment and labelling of "risky" service users.'⁴⁶⁰

8.45. In our view, the question which must be asked – but is unfortunately absent from the Restrictive Practices Issues Paper – is how can the use of restrictive practices be prohibited? Our answer to this more appropriate question would be that restrictive practices need to be prohibited by criminal law, laws for substitute decision-making frameworks need to be abolished, and other laws and policies supporting restrictive practices (e.g. those regulating service provision such as NDIS and aged care) need to be amended to explicitly prohibit the use of restrictive practices. Consideration also needs to be given to the foundational role of the common law doctrine of *parens patriae* in enabling the violence of restrictive practices. Additional to these legal reforms, laws should also be introduced to provide for redress of violence experienced through restrictive practices.

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

8.46. The term ‘behaviours of concern’ is premised on the same ableism that underpins ‘challenging behaviour’. Both of these terms individualise, pathologise and neutralise disabled people’s legitimate responses to their living arrangements and experiences of oppression, structural discrimination and violence. As such, Question 12 is problematic because it takes for granted the concept of ‘behaviours of concern’ as a valid concept through which to both understand the experiences and circumstances of people with disability and justify use of restrictive practices. Moreover, this question is narrowly drawn to focus on alternatives to respond to behaviour, rather than alternatives to respond to the structural circumstances of discrimination and oppression in which restrictive practices are used and are lawful. Thus, rather than Question 12 confronting the concept of ‘behaviours of concern’ per se and the violence and injustice it enables, this question instead encourages the proliferation of additional options for intervening in the bodies and lives of people with disability on the basis of an inherently problematic behavioural concept.

8.47. Any consideration of alternatives to restrictive practices should be situated in a broader framework of prohibition of restrictive practices and abolition of the legal frameworks that enable restrictive practices. Otherwise, the actual use of any ‘alternatives’ will always be subject to discretion and will leave in place broader structural conditions of ableism that legitimate restrictive practices as a valid choice from a range of options.

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

8.48. The Royal Commission has not identified various interventions as restrictive practices that are targeted at women and girls with disability, including non-consensual and coercive sterilisation, menstrual suppression, contraception, abortion, forced child removal and denial of support for sexual activity and intimate relationships. This is a serious omission due to the gendered nature of these practices, the enduring resistance of Australian Governments to prohibiting sterilisation, and the present resistance of the Australian Government to NDIS-funded support for sexual activity.

8.49. As per our response to Question 11 above, the Royal Commission has overlooked the question of how to prohibit restrictive practices and abolish substitute decision-making and compulsory treatment.

- 8.50. The Royal Commission has overlooked the question of how to redress violence through restrictive practices. The Royal Commission observed in the DRC Interim Report that it would explore redress in future work.⁴⁶¹ While it is encouraging that the Royal Commission recognises redress is an area of future exploration, we are concerned that the scope of this exploration might be limited to group homes and supported accommodation. This would not cover historical or contemporary instances of violence, abuse, neglect and exploitation in largescale institutions or other settings and contexts. It is also unclear whether its intended exploration of restrictive practices will extend to restrictive practices given the case study prompting this point related to unlawful sexual and physical assault.⁴⁶²
- 8.51. On a related note, the Royal Commission has overlooked access to justice in relation to restrictive practices – either to seek redress for their use (notably when they are unauthorised or unlawful under current law) or to have substitute decision-making orders removed or challenge the legality of restrictive practices.
- 8.52. The Royal Commission has overlooked whether restrictive practices breach international human rights law. Given restrictive practices constitute violence, discrimination and torture under international human rights law, this is a significant omission particularly when coupled with the focus on regulation of restrictive practices in other questions. The Terms of Reference explicitly state that:
- Australia has international obligations to take appropriate legislative, administrative and other measures to promote the human rights of people with disability, including to protect people with disability from all forms of exploitation, violence and abuse under the Convention on the Rights of Persons with Disabilities.*⁴⁶³
- 8.53. The Royal Commission has overlooked the economic dynamics of the use of restrictive practices. Instead of taking at face value disability services' justifications for their use of restrictive practices, it is important to interrogate the financial benefits to disability services associated with use of restrictive practices.
- 8.54. The Royal Commission has overlooked the ableism embedded in the categories of 'challenging behaviour' and 'behaviours of concern' that provide scientific/medical legitimacy to the use of restrictive practices.



APPENDIX 1

APPENDIX 1: RELEVANT CONCLUDING COMMENTS FROM UN TREATY BODIES

This section of the Submission is taken from the 2019 publication: 'Disabled People's Organisations Australia and the National Women's Alliances, *The Status of Women and Girls with Disability in Australia, Position Statement to the Commission on the Status of Women (CSW) Twenty-Fifth Anniversary of the Fourth World Conference on Women and the Beijing Declaration and Platform for Action 1995.*' Women With Disabilities Australia, 2019. Written by Carolyn Frohmader for and on behalf of WWDA and DPO Australia. Available at: <https://wwda.org.au/wp-content/uploads/2020/06/The-Status-of-Women-and-Girls-with-Disability-Asustralia.pdf>

The UN has made numerous recommendations, called concluding comments or concluding observations following periodic reviews of Australia under different treaty bodies. The following provides a summary of the most recent key recommendations from these treaty bodies that are relevant to restrictive practices, substituted decision-making and compulsory treatment, and violence, abuse, neglect and exploitation.

Equality, Non-Discrimination and Participation

In its 2019 Concluding Observations, the UN CRPD Committee expressed and reiterated a number of concerns from its 2013 initial review of Australia: the lack of an effective legislative framework to protect people with disability from systemic, intersectional and multiple forms of discrimination; a lack of an effective monitoring mechanism and insufficient resources to effectively implement the NDS; limited opportunities for women and girls with disability to participate in the development of policies regarding the rights of women and gender equality; and the lack of nationally consistent measures for the collection and public reporting of disaggregated data on the full range of obligations contained in the Convention. The Committee recommended that Australia: enact a comprehensive national human rights law; strengthen anti-discrimination laws to address and prohibit systemic, intersectional and multiple forms of discrimination; provide sufficient resources and establish a formal monitoring mechanism for the NDS; and develop a national disability data framework to ensure nationally consistent measures for the collection and public reporting of disaggregated data on the full range of obligations contained in the Convention, especially with regard to women, children and Indigenous persons with disabilities. The Committee further recommended that Australia strengthen measures to address multiple and intersectional forms of discrimination against women and girls with disability and, in particular, adequately support organisations and networks of women and girls with disability, particularly those representing Indigenous women and girls with disability, to engage in all initiatives to promote gender equality and ensure their effective participation in the development of policies for gender equality and the advancement of women and girls.

The Committee on the Elimination of Discrimination against Women reviewed Australia's implementation of CEDAW⁴⁶⁴ in 2018.⁴⁶⁵ The Committee expressed its concern at the lack of harmonisation of anti-discrimination legislation, and the absence of a Charter of Human Rights that guarantees equality between women and men or a general prohibition of discrimination against women. Amongst other things, the Committee recommended that Australia harmonise federal, state and territory legislation against discrimination in line with the Convention; and fully incorporate the Convention into national law by adopting a Charter of Human Rights that includes a guarantee of equality between women and men and prohibits discrimination against women. The Committee further recommended that Australia adopt a comprehensive national gender equality policy with performance indicators and ensure sufficient human and financial resources to

coordinate and monitor the implementation of that policy.

In 2019, the Committee on the Rights of the Child provided its Concluding Observations⁴⁶⁶ to Australia following its review. The Committee recommended that Australia: enact comprehensive national child rights legislation fully incorporating the Convention and providing clear guidelines for its consistent and direct application throughout Australia; ensure adequate resources for the Parliamentary Joint Committee on Human Rights to effectively examine all proposed legislation and its impact on children's rights; ensure that the National Children's Commissioner has adequate and sufficient human, technical and financial resources to implement and monitor the application of the Convention; and establish by law mandatory consultations between the National Children's Commissioner and children on issues that affect them and ensure that the results of those consultations and any other recommendations made by the Commissioner are taken into consideration in law and policymaking. The Committee also recommended that Australia adopt a national comprehensive policy and strategy on children that encompasses all areas of the Convention, with sufficient human, technical and financial resources for its implementation; establish appropriate mechanisms and inclusive processes so that civil society, the community and children specifically may participate in all stages of the budget process, including formulation, implementation and evaluation; and ensure that data collected on children's rights cover all areas of the Convention, in particular those relating to violence, alternative care, natural disasters and children in conflict with the law, that they are disaggregated by age, sex, disability, geographic location, ethnic origin, national origin and socioeconomic background, and that they identify children in situations of vulnerability, such as Indigenous children, children with disability and asylum-seeking, refugee and migrant children.

In its 2017 Concluding Observations⁴⁶⁷ on the fifth periodic report of Australia,⁴⁶⁸ the Committee on Economic, Social and Cultural Rights expressed its concern that women continue to experience disadvantages across key areas (including work, health, education, and housing) and recommended that Australia intensify its efforts to address the obstacles to achieving substantive equality between men and women, including through the strengthening of temporary special measures. The Committee also recommended that Australia consider introducing a federal Charter of Rights that guarantees the full range of economic, social and cultural rights. In relation to the NDS 2010-2020, the Committee expressed its concern at the slow progress in its implementation and its weak accountability and implementation mechanisms. The Committee recommended that Australia ensure full implementation of the NDS by focusing on all the six areas covered and allocating the necessary resources. The Committee further recommended that Australia strengthen accountability mechanisms to ensure that people with disability fully enjoy their economic, social and cultural rights.

In its 2017 Concluding Observations⁴⁶⁹ on the sixth periodic report of Australia under the ICCPR,⁴⁷⁰ the Human Rights Committee recommended that Australia should take measures, including considering consolidating existing non-discrimination provisions in a comprehensive federal law, in order to ensure adequate and effective substantive and procedural protection against all forms of discrimination on all the prohibited grounds, including religion, and intersectional discrimination, as well as access to effective and appropriate remedies for all victims of discrimination.

Freedom from Violence, Abuse, Neglect and Exploitation

In September 2019, the UN CRPD Committee adopted its Concluding Observations following its review of Australia's compliance with the CRPD.⁴⁷¹ The Committee expressed concern about: the lack of oversight, complaint and redress mechanisms for people who are not eligible for the NDIS and who experience violence, particularly women with disability; the lack of resources and

redress mechanisms available for people with disability to participate in the Royal Commission into Violence, Abuse, Neglect and Exploitation of Persons with Disabilities; the non-implementation of recommendations in the report from the AHRC, 'A Future without Violence'; the lack of explicit reference to women and girls with disability in the National Plan to Reduce Violence against Women and their Children 2010-2020; the insufficient expertise and structural barriers within services dealing with domestic violence, sexual assault and related crises to adequately support women and girls with disability; and the limited number and scope of instruments to collect data on violence against women and girls with disability. The Committee recommended that Australia: establish a national accessible oversight, complaint and redress mechanism for all people with disability in all settings, particularly older women with disability; ensure adequate resources and a redress mechanism for the Royal Commission; implement the recommendations contained in the AHRC report; ensure inclusion of women and girls with disability in the National Plan; ensure accessible gender and age sensitive services that are inclusive of women and girls with disability; and address the methodological restrictions in data collection instruments used to capture data on violence against women and girls with disability.

In its 2018 review⁴⁷² of Australia's eighth periodic report⁴⁷³ under CEDAW, the CEDAW Committee expressed its concern at the lack of national legislation prohibiting all forms of gender-based violence against women. The CEDAW Committee recommended that the Australian Government adopt Commonwealth legislation that is in line with the Convention and prohibits all forms of gender-based violence against women and girls and shift the power to legislate on this matter to the Commonwealth Parliament. The Committee also recommended that Australia should expedite the establishment of the national data collection framework and guarantee that data on femicide and violence against women with disability is systematically collected under the framework.

In its 2019 Concluding Observations⁴⁷⁴ of Australia, the Committee on the Rights of the Child expressed its serious concerns about the high rates of violence against children in the home, that girls between the ages of 10-19 years suffer the highest rate of sexual abuse, that Indigenous children continue to be disproportionately affected by family and domestic violence, including sexual violence, that children with disability are more vulnerable to violence, neglect and abuse, including sexual abuse, and that girls with disability are forced to undergo sterilisation procedures. The Committee recommended that Australia: prioritise implementation of violence prevention and response measures for children, particularly girls, of all ages within the National Framework for Protecting Australia's Children 2009-2020 (National Framework) and the National Plan to Reduce Violence against Women and their Children 2010-2022 (National Plan); ensure that the National Centre for the Prevention of Child Sexual Abuse establishes a comprehensive standard with regard to intervention in cases of child sexual abuse to avoid the re-traumatisation of child victims; provide child-specific therapeutic interventions and counselling to child victims of violence, in addition to the support provided to families; substantially increase family violence prevention and responses related to Indigenous children; review the National Framework and the National Plan to ensure they adequately prevent violence against children with disability and prohibit by law forced or coerced sterilisation of girls with disability; and enact legislation to prohibit unnecessary medical or surgical treatment on intersex children and provide support and counselling to families of intersex children.

In its 2017 Concluding Observations⁴⁷⁵ on the fifth periodic report of Australia,⁴⁷⁶ the Committee on Economic, Social and Cultural Rights expressed its concern about the high levels of violence and abuse against persons with disability, especially those with intellectual disability and women with disability, placed in institutions or residences. The Committee also articulated its concern at the lack of effectiveness of oversight and complaint mechanisms in alternative care settings. The Committee recommended amongst other things, that Australia redouble its efforts to combat domestic violence against women and children, including among Indigenous peoples; increase accommodation and support services, especially in rural and remote areas; fully implement the recommendations in the inquiry report by the Senate Community Affairs References Committee into violence, abuse and neglect against people with disability in institutional and residential

settings (2015); and pay particular attention to ensure that women with disability who are victims of domestic violence can claim their rights.

In 2017, the Human Rights Committee released its Concluding Observations⁴⁷⁷ on the sixth periodic report of Australia under the ICCPR.⁴⁷⁸ While welcoming the various measures taken to address violence against women, the Committee specifically noted its concern that violence against women in Australia continues to have a disproportionate effect on women with disability and Indigenous women. In relation to violence against women with disability, the Committee recommended that Australia improve support services to women with disability who are victims of domestic violence, including through the implementation of the relevant recommendations from the STVP.⁴⁷⁹ The Committee also recommended that all allegations of sexual abuse, regardless of the time of their commission, are promptly, impartially, thoroughly and effectively investigated and perpetrators are brought to justice and, if found responsible, are punished in accordance with the gravity of their acts.

The Committee against Torture reviewed the combined fourth and fifth periodic reports of Australia⁴⁸⁰ in 2014. The Concluding Observations⁴⁸¹ from the review noted the Committee's concern that violence against women in Australia disproportionately affects women with disability and Indigenous women. The Committee recommended amongst other things that Australia redouble its efforts to prevent and combat all forms of violence against women and increase its efforts to address violence against women with disability and Indigenous women.

Health

In 2019, the UN CRPD Committee provided its Concluding Observations⁴⁸² on the combined second and third periodic report of Australia.⁴⁸³ The Committee expressed concern about: the significantly lower life expectancy of people with disability; the significant number of people with disability expressing suicidal ideation, particularly within Indigenous communities; the high rate of premature, unexpected and avoidable deaths among people with disability in care settings; the significantly poorer health status of people with disability; and the limited access to adequate, affordable and accessible health services and equipment, in particular for women and children with disability, Indigenous peoples with disability, people with disability living in institutions and in remote areas, and those with intellectual or psychosocial disability. The Committee also expressed its concern that: parents with disability are more likely to have their children removed from their care on the basis of disability; the lack of support to parents with disability to exercise parental responsibilities; and the discrimination experienced by women with disability, lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) persons with disability in accessing assisted reproductive technologies. Further, the Committee expressed concern about: the medical model assessment to determine eligibility for the NDIS; the lack of equal opportunities in the NDIS particularly for older persons with disability, Indigenous peoples with disability, people with disability from culturally and linguistically diverse backgrounds and people with intellectual or psychosocial disability; and the low percentage of women and girls with disability that have access to services under the NDIS. The Committee recommended that Australia: address the low life expectancy of people with disability; ensure that national mental health and suicide prevention plans include measures for people with disability; develop culturally appropriate measures to prevent, identify and address the high rate of suicide among Indigenous populations; ensure training of professionals working with people with disability including health, social, education and community workers; ensure equitable access to affordable, accessible, quality and culturally sensitive medical equipment and health services, including sexual, reproductive and mental health services; ensure that the free and informed consent of the person concerned is provided prior to any medical treatment; and that health care practitioners receive training on the human rights model of disability. The Committee also recommended that Australia: ensure that no child is separated from parents because of the disability of one or both parents; adopt comprehensive

gender and culturally specific parenting and family support measures for parents with disability; and that women with disability and LGBTIQ people with disability have equal access to assisted reproductive technologies. Further, the Committee recommended that: the NDIS be aligned with the human rights model of disability; there is equal access to services under the NDIS for women and girls with disability, particularly those of Indigenous backgrounds; NDIS procedures are simplified, transparent, publicly available and accessible; the NDIS meets the diverse and intersecting requirements of persons with disability in all areas; and provide adequate support and equal opportunities to specific groups of people with disability who are disadvantaged or not eligible for the NDIS.

In its 2018 review⁴⁸⁴ of Australia's eighth periodic report⁴⁸⁵ under CEDAW, the CEDAW Committee recommended that Australia increase its efforts and resources to address the deteriorating mental health situation of women and girls, in particular young mothers, Indigenous women, women with disability, women in detention, migrant women and their daughters, lesbian, bisexual and transgender women and intersex persons, and reinforce preventive measures. The Committee also recommended that Australia allocate sufficient funding to the NDIS to extend coverage for mental health services to women and girls with all types of mental health conditions and disabilities. The Committee further recommended that Australia finalise the national strategic framework for the mental health and social and emotional well-being of Indigenous peoples, guarantee appropriate resources for its implementation and address intergenerational trauma in culturally appropriate and effective ways. In relation to refugee and asylum-seeking women and girls, the Committee recommended that Australia ensure they have access to comprehensive, adequate and accessible sexual and reproductive health services and information, including to emergency contraception and abortion services.

In its 2019 Concluding Observations⁴⁸⁶ of Australia, the Committee on the Rights of the Child expressed its serious concern about the increase in numbers of children with mental health problems, that suicide is the leading cause of death among those aged 15-24, children under 14 years of age have limited access to mental health services, and the limited child-specific measures in the Fifth National Mental Health and Suicide Prevention Plan. The Committee also expressed concern that Australia has one of the highest rates of children aged 5-14 years diagnosed with attention deficit hyperactivity disorder (ADHD) with a dramatic increase in the number of psychostimulant drug prescriptions. The Committee recommended that Australia: invest in the underlying causes of suicide and poor mental health among children; ensure that the Fifth National Mental Health and Suicide Prevention Plan includes a clear focus on children; that mental health service delivery to children in vulnerable situations, including children with disability, is prioritised; strengthen measures to ensure that psychostimulant drugs are only prescribed to children with ADHD as a last resort and only after an individualised assessment of the child's best interests; inform children with ADHD and their parents about the side effects of psychostimulant drugs and about non-medical alternatives; increase the availability of child-friendly mental health services including to children under 14 years. The Committee also recommended that Australia promptly address the disparities in health status for children with disability, Indigenous children, children living in remote or rural areas and children in alternative care; to strengthen measures to prevent teenage pregnancies among Indigenous girls; and to continue to provide sexual and reproductive health as part of the mandatory school curriculum. In its 2017 Concluding Observations⁴⁸⁷ on the fifth periodic report of Australia,⁴⁸⁸ the Committee on Economic, Social and Cultural Rights expressed its concern at the poor health status of Indigenous peoples, refugees and asylum seekers. The Committee recommended that Australia redouble its efforts to achieve the health targets outlined in the Closing the Gap strategy and take effective steps to ensure refugees and asylum seekers are able to exercise their right to the highest attainable standard of health, with particular attention to mental health services. The Committee articulated its extreme concern with regard to the negative impact on mental health of the prolonged detention of children in the regional processing centres and recommended that Australia ensure access to appropriate child and family psychiatric care by asylum seekers and support for their social integration.

In 2017, the Human Rights Committee released its Concluding Observations⁴⁸⁹ on the sixth periodic

report of Australia under the ICCPR.⁴⁹⁰ The Committee recommended that Australia address the conditions of detention in immigration facilities, provide adequate mental health care, refrain from applying force or physical restraints against migrants and ensure that all allegations of use of force against them are promptly investigated, that perpetrators are prosecuted and, if convicted, punished with appropriate sanctions, and that victims are offered reparation. In December 2017, the Committee on the Elimination of Racial Discrimination released its Concluding Observations⁴⁹¹ of Australia's compliance under the International Convention on the Elimination of All Forms of Racial Discrimination. The Committee expressed its concern at the high rate of suicide among Indigenous peoples, and the lack of specific programmes for Indigenous peoples with disability. The Committee recommended, amongst other things, that Australia adopt and implement other adequately resourced programmes, including specific programmes for Indigenous peoples with disability, in consultation with them, and increase support for, and investment in, Indigenous community- controlled health services and programmes. The Committee further recommended that Australia collect data disaggregated by ethnicity, Indigenous peoples, age, gender, disability, sexual orientation and gender identity, on the extent of suicide and report on the measures adopted to address it.

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APPENDIX 2

APPENDIX 2: ENDNOTES

- 1 Committee on the Rights of Persons with Disabilities (2018) General comment No. 7, UN Doc No. CRPD/C/GC/7.
- 2 Australian Government, 'The National Disability Abuse and Neglect Hotline', Job Access <<https://www.jobaccess.gov.au/complaints/hotline>>; See also Australian Government Department of Social Services, 'National Disability Abuse and Neglect Hotline Data' (27 January 2021) <<https://www.dss.gov.au/disability-and-carers/publications-arivicles/general/national-disability-abuse-and-neglect-hotline-data-0>>.
- 3 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Restrictive Practices Issues Paper (26 May 2020) 1.
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Recommendation 17: Regulation of restraints

1. The Quality of Care Principles 2014 (Cth) should be amended by 1 January 2022 to provide that the use of restrictive practices in aged care must be based on an independent expert assessment and subject to ongoing reporting and monitoring. The amendments should reflect the overall principle that people receiving aged care should be equally protected from restrictive practices as other members of the community. In particular, restrictive practices should:
 - a. be prohibited unless:
 - i. recommended by an independent expert, accredited for the purpose by the Quality Regulator, as part of a behaviour support plan lodged with the Quality Regulator and reviewed quarterly by the expert, with reports on implementation of the behaviour support plan being provided to the Quality Regulator on a monthly basis, or
 - ii. when necessary in an emergency to avert the risk of immediate physical harm, with any further use subject to recommendation by an independent expert under Recommendation 17(1)(a)(i), and with a report of the restraint to be provided with reference to the matters in Recommendation 17(1)(b) as soon as practicable after the restraint starts to be used; and
 - b. only be used:
 - i. as a last resort to prevent serious harm after the approved service provider has explored, applied and documented alternative, evidence-based strategies to mitigate the risk of harm
 - ii. to the extent necessary and proportionate to the risk of harm
 - iii. for the shortest time possible to ensure the safety of the person or others
 - iv. subject to monitoring and regular review (to be stipulated in the behaviour support plan) by an approved health practitioner
 - v. in accordance with relevant State or Territory laws and with the documented informed consent of the person receiving care or someone authorised by law to give consent on that person's behalf
 - vi. in the case of chemical restraint, if prescribed by a doctor who has documented the purpose of the prescription.
2. In making these amendments, the Australian Government should consider whether any adjustments or additions are warranted as a result of the statutory review of Part 4A of the Quality of Care Principles 2014 (Cth).

3. The amendments should also provide that:
 - a. any use of restrictive practices that is not in accordance with the statutory scheme should be reportable under the updated serious incident reporting scheme, and
 - b. any breach of the statutory requirements should expose the approved provider to a civil penalty at the suit of the regulator. If a person directly affected by the breach wants to be compensated, the regulator or the person should have the power to seek an order for compensation.
4. In the interim, the repeal of Part 4A of the Quality of Care Principles 2014 (Cth) should be delayed until 31 December 2021.
5. Following the conclusion of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, the Australian Government should consider the applicability to aged care of any findings from that Royal Commission about restrictive practices and make further legislative amendments required to ensure that the treatment of people receiving aged care services is consistent with the treatment of other members of the community.: Royal Commission into Aged Care Quality and Safety, 'Final Report: Care, Dignity and Respect, Volume 1, Summary and Recommendations' (n 51) 221–222. See also Royal Commission into Aged Care Quality and Safety, Final Report: Care, Dignity and Respect, Volume 3A, the New System (Commonwealth of Australia) 116–117.
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Winner

National Human Rights Award 2001

Winner

National Violence Prevention Award 1999

Winner

Tasmanian Women's Safety Award 2008

Nominee

UNESCO Prize for Digital Empowerment of Persons with Disabilities
2021

Nominee

French Republic's Human Rights Prize 2003

Nominee

UN Millennium Peace Prize for Women 2000

Certificate of Merit

Australian Crime & Violence Prevention Awards 2008

Nominee

National Disability Awards 2017