



# Submission to the Evidence Advisory Committee

March 2026

# Contents

<b>About Inclusion Australia</b> .....	<b>3</b>
<b>Background</b> .....	<b>4</b>
<b>Evidence on Positive Behaviour Support</b> .....	<b>5</b>
The use and impact of restrictive practices for people with an intellectual disability and families: a brief review of current evidence.....	6
Lessons from the Disability Royal Commission .....	6
<b>Changing understandings of ‘behaviours of concern’</b> .....	<b>7</b>
A holistic understanding of behavioural drivers .....	7
Supported decision-making .....	8
Early access to communication support.....	8
A trauma-informed lens .....	8
Belonging in ordinary community life .....	9
<b>Conclusion</b> .....	<b>10</b>
<b>Reference list</b> .....	<b>0</b>



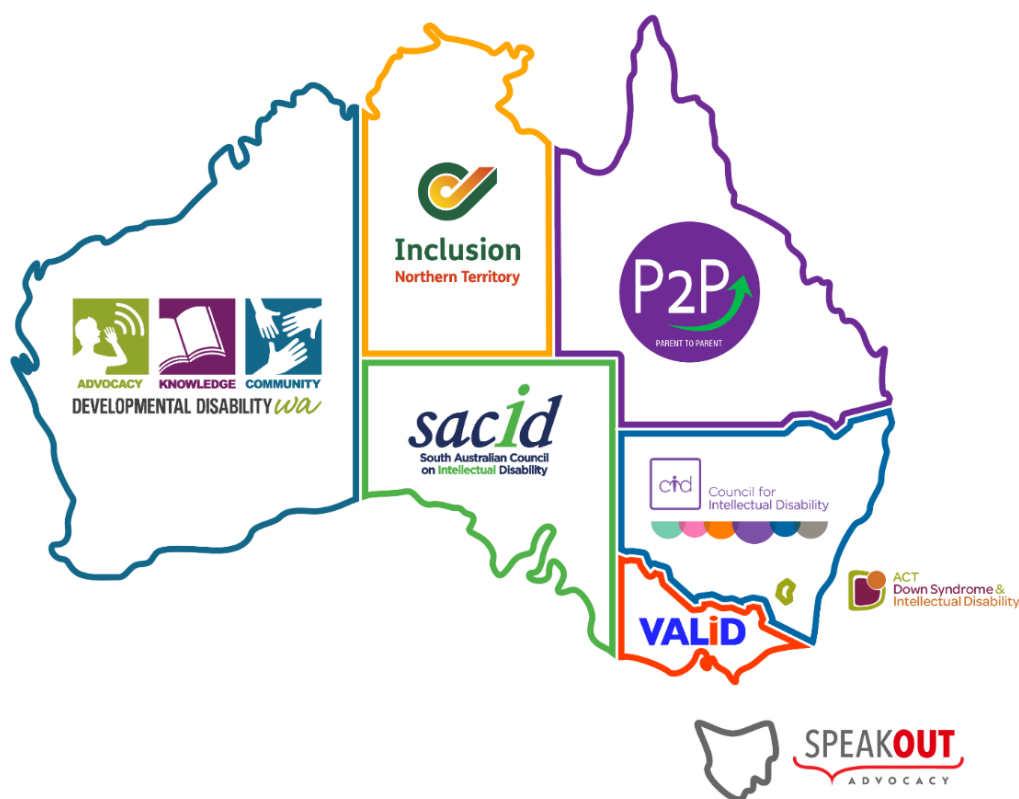
## About Inclusion Australia

Inclusion Australia (IA) is the national peak organisation representing the rights and interests of Australians with an intellectual disability and their families. Founded more than 70 years ago in 1954, our mission is to work with people with an intellectual disability, their families and our members to make positive change.

Our strength is in our national representation and our connection to our community. We have a member organisation in every state and territory across Australia:

- ACT Down Syndrome and Intellectual Disability (ACT DSID)
- Council for Intellectual Disability (NSW)
- Developmental Disability WA (DDWA)
- Inclusion Northern Territory (Inclusion NT)
- Parent to Parent (P2P, Queensland)
- South Australian Council on Intellectual Disability (SACID)
- Speak Out Advocacy (Tasmania)
- Victorian Advocacy League for Individuals with Disability (VALID).

Our governance is supported by Our Voice, an official subcommittee of our Board comprised of people with an intellectual disability. Our work is further guided by our Policy Reference Group, also led and comprised of people with an intellectual disability across Australia. The Policy Reference Group members come from diverse backgrounds, including First Nations people, people from multicultural communities, and LGBTIQ+ people. They bring combined decades of experience in advocacy and direct experience of many government services and reform processes. Additionally, half of our internal team are people with an intellectual disability or family members, embedding lived experience across all aspects of our work.



Inclusion Australia acknowledges the Traditional Owners of Country on which this submission was written and throughout Australia. We recognise their continuing connections to land, waters and skies and pay our respects to Elders past and present.

# Background

Inclusion Australia welcomes the opportunity to provide input to the Evidence Advisory Committee (EAC) consultation on evidence relating to disability supports.

In this submission we focus primarily on the evidence relating to Positive Behaviour Support (PBS), which is one of the support approaches identified in the consultation materials. PBS plays a significant role in the way disability services respond to behaviours commonly described as “of concern” or “challenging”, and is closely connected to the regulation and use of restrictive practices within the NDIS.

Inclusion Australia has undertaken substantial policy and research work in relation to restrictive practices, behaviour support and the broader structural factors that shape people’s experiences using disability services. This work has drawn on evidence presented through the Disability Royal Commission, as well as broader research examining the drivers of restrictive practices and the effectiveness of behaviour support approaches.

The following sections therefore outline key findings from the research literature relating to PBS and behaviour support, alongside the broader evidence regarding restrictive practices and the conditions that contribute to their use. This evidence highlights important limitations in the current knowledge base and underscores the importance of focusing on the environmental, relational and systemic factors that shape people’s experiences within disability services, alongside behavioural interventions, and what kind of supports are necessary to enable people with an intellectual disability to live inclusive lives.

This submission also draws on the expertise and insights provided by Inclusion Australia’s Complex Needs Family Reference Group. This group began as a [service-for-one](#) Community of Practice for families who run a service-for-one with their family member. Five family members from around Australia provided input to this submission.

## Evidence on Positive Behaviour Support

A review of the national and international literature undertaken for the Disability Royal Commission indicates that the evidence base supporting PBS is characterised by significant limitations. Many studies rely on very small samples, including single-case studies or pilot programs involving only a small number of families. These limitations are discussed below, and are drawn from the report commissioned by the Disability Royal Commission.<sup>1</sup>

Much of the existing research focuses on training staff to implement PBS approaches. While staff training can shift how behaviour is interpreted, there is limited evidence demonstrating that such training leads to improved outcomes for people with disability. Very few studies examine quality-of-life outcomes directly.

The literature also places significant emphasis on the quality of behaviour support plans, largely based on the assumption that better training and stronger adherence to PBS principles will lead to higher quality plans and improved outcomes. However, research examining behaviour support plans in Australian disability services has consistently found that many behaviour support plans are of poor quality. Studies have found that plans frequently lack the elements necessary to meet peoples' support needs, and that overall quality scores are often low even in jurisdictions with legislative requirements governing behaviour support planning. Even where training has improved the technical quality of plans, there is little evidence demonstrating that behaviour support plans are implemented consistently in practice or that they produce meaningful improvements in people's lives.

This gap between behaviour support plans and meaningful outcomes is reflected in lived experience. One family member in the Complex Needs Family Reference Group described receiving a behaviour support plan that consisted of "a fabulous shiny folder with all sorts of bits of paper in it," but reported that "the first 18 months was useless" because there was no practitioner with the expertise to translate the plan into practice. The assigned worker "did not have the expertise or the experience or the ability to gain trust," and meaningful progress only occurred once a skilled practitioner was engaged.

Across the literature more broadly, findings regarding the effectiveness of PBS are mixed and often inconclusive. Some studies report reductions in behaviours perceived as problematic or improvements in organisational practices, but these results are typically based on small samples or studies that do not meet established research standards. Larger trials have often failed to demonstrate significant effects. In addition, many studies focus on short-term behavioural outcomes rather than longer-term changes in quality of life or wellbeing.

Perhaps the most significant insight to emerge from the research is that where positive outcomes do occur, they are often associated with changes to the person's environment and the quality of support they receive, rather than with behavioural techniques alone.

Case studies frequently show improvements when staff adopt non-confrontational communication and people are given greater autonomy and choice – including through supported decision-making. Similarly, when meaningful activities are available, sensory environments are adjusted, communication supports are introduced, or when medication regimes are reconsidered, improvements are often also apparent.

This is strongly reflected in practice examples shared by families as part of the Complex Needs Family Reference Group. One family member described a practitioner's approach as being "regulation-based", asking: "is it behaviour, or is he just dysregulated?" Their focus moved to keeping the person regulated through sensory supports, predictable routines, and reduced demands, rather than reacting to incidents after they occur. Another family described embedding supports into everyday life by centring the person's interests, noting that "if you treat him with respect and respect his interests, he will respond accordingly."

Importantly, several family members noted that these approaches were developed independently of formal PBS. As one parent stated, "it's got nothing to do with positive behaviour support – it's about knowing the person really well." In these cases, PBS practitioners were described as playing a largely administrative role, acting as a "sounding board" or documenting strategies already developed by families.

These findings align with a broader body of research indicating that behaviours commonly labelled as "challenging" or "of concern" are frequently expressions of distress, unmet needs or resistance within environments that are restrictive or poorly matched to the person. From this perspective, improvements attributed to PBS may in many cases reflect improvements in the quality of a person's environment, relationships and supports rather than the effectiveness of behavioural interventions themselves.

This evidence suggests that while PBS has become a widely adopted framework for addressing ‘behaviours of concern’ and reducing restrictive practices, the strength of the evidence base remains limited. It also highlights the importance of focusing policy attention not only on behavioural interventions, but on the broader structural and environmental conditions that shape people’s experiences within disability services, as well as the extent to which family member expertise is unearthed and meaningfully applied to interventions.

In this context, it is also important to consider the broader evidence regarding the use of restrictive practices and their impact on people with an intellectual disability.

## The use and impact of restrictive practices for people with an intellectual disability and families: a brief review of current evidence

The *NDIS Act 2013* defines a restrictive practice as ‘any practice or intervention that has the effect of restricting the rights or freedoms of movement of a person with disability’. There are five restrictive practices that are subject to regulation and oversight by the NDIS Quality and Safeguards Commission: chemical restraint; mechanical restraint; physical restraint; environmental restraint; and seclusion.

The use of medication to restrain people with disability is one form of restrictive practice that is enabled by the health system and is common in mental health settings.<sup>2</sup> Research indicates medication can be given to people with disability as a matter of routine, without any or sufficient therapeutic purpose to explain its use.<sup>3</sup> In the Disability Royal Commission’s sixth public hearing, Commissioners heard that the number and dosage levels of such medications administered to people with an intellectual disability are sometimes so significant, they constitute abuse.<sup>4</sup>

Concerns about the application of restrictive practices were also reflected in lived experience. Families described situations where restrictive approaches were proposed by some practitioners or providers as first-line responses, such as removing access to everyday items or environments. One family member recounted being advised to remove taps to prevent water use, stating: “we were like, no ... that’s part of his regulation.” Instead, they implemented less restrictive alternatives, such as modifying access while maintaining autonomy.

## Lessons from the Disability Royal Commission

Evidence from the Disability Royal Commission showed that people with an intellectual disability, especially people with complex support needs, are among the most likely to experience restrictive practices, especially chemical restraint.<sup>5</sup>

Research indicates that restrictive practices are routinely used in group homes,<sup>6</sup> and the Disability Royal Commission heard that their use in group homes is increasing.<sup>7</sup> Restrictive practices may also be used in the community, such as in day programs or other disability service settings.

People with disability in detention settings, which includes a high number of First Nations people with an intellectual disability, are also at a high risk of restrictive practices. Prisoners and youth detainees with disability, particularly people with an intellectual disability, are disproportionately secluded in solitary confinement for long periods of time.<sup>8</sup>

In an extensive research report commissioned by the Disability Royal Commission, it was found that:

*The research literature is unequivocal: people with disability are subject to the greatest use of restrictive practice in segregated and congregated contexts where people with disability are clustered together.<sup>9</sup>*

The report suggested that people with disability’s lack of choice and autonomy within those settings is a distinguishing factor that contributes to the increased use of restrictive practices. We also know that people with an intellectual disability are more likely than other people to experience such settings.

There was significant evidence about the need for and prerequisites of good quality behaviour support heard across a range of the Disability Royal Commission’s hearings, submissions and research program, including:

- [Public hearing 6 - psychotropic medication, behaviour support and behaviours of concern](#)
- [Safeguards and Quality Issues Paper](#)
- [Restrictive Practices Issues Paper](#)

- [The University of Melbourne, University of Technology Sydney, and the University of Sydney: Restrictive practices: a pathway to elimination, a research report commissioned by the Disability Royal Commission.](#)

Noting this, as well as the evidence from the Disability Royal Commission, there is a clear need for targeted strategies that work to address the pathologisation of ‘behaviour’ and the ways this incentivises the use, and in many cases over-use,<sup>10</sup> of restrictive practices.

## Changing understandings of ‘behaviours of concern’

It is becoming increasingly accepted that the concept of ‘behaviours of concern’ or ‘challenging behaviour’ is culturally and socially constructed, reflecting dominant social attitudes towards people with disability.<sup>11</sup>

Importantly, labelling some behaviours as ‘concerning’ or ‘challenging’ relies on an interpretation or judgement by *someone else*, who is declaring this behaviour to be “dangerous, frightening, distressing or annoying”,<sup>12</sup> rather than centring the person with disability themselves or considering their needs – particularly their unmet needs. There is also substantial literature establishing ‘behaviours of concern’ as an important and valid part of a person’s communication.<sup>13</sup>

Paul Ramcharan and colleagues also note that ‘behaviours of concern’ may equally define the service a person may be receiving or a setting a person is experiencing life in, rather than being pathologically and unidirectionally attributed to people with disabilities.<sup>14</sup> They suggest:

*A behaviour of concern is likely to be produced by ‘an environment of concern’ ... behaviours seen as being ‘of concern’ can be understood better as adaptive behaviours to maladaptive environments ... and should be seen as legitimate responses to difficult environments and situations, and not a reason for restrictions designed to change the person and their behaviour.*<sup>15</sup>

This reframing is strongly echoed in lived experience. Several family members explicitly rejected the framing of “behaviours of concern,” instead describing what is often labelled as behaviour as distress, regulation difficulty, or communication. As one family member stated: “we all know challenging behaviour is really a distress response ... about being safe.”

Research has also shown that “restrictive practices may form part of a ‘vicious cycle’ in which the psychological instability and distress they generate leads to more behaviours that in turn result in further restrictive practices”.<sup>16</sup> This was also a key finding of a research report commissioned by the Disability Royal Commission, which found that restrictive practices (as responses to ‘behaviours of concern’) take place within an “ecological system of violence, coercion, and control”.<sup>17</sup>

## A holistic understanding of behavioural drivers

Inclusion Australia has developed a model, included in the Appendix, that explores a holistic understanding of the factors that drive ‘behaviour’. This means bringing an understanding of behaviour that considers the situation at that moment in time as well as the person’s unique experiences and whole-of-life context to the greatest extent possible.

This approach means seeing ‘behaviour’ as a legitimate response to a difficult situation and interpreting this in the context of the person’s current life and past experiences. That situation may be one in which the person is disempowered, have a range of unmet needs, feel unsafe, and is expressing themselves according to their own ways of communicating

Importantly, this process is not unique to people with an intellectual disability: this is how we all experience and express what is happening to us.

This approach moves us away from seeing ‘behaviours’ as isolated events or things that happen in a vacuum, that need to be ‘managed’ according to a pre-determined procedure, rather than addressing the underlying causes within a person’s whole-of-life context.

We have identified four factors which we believe are necessary to develop these holistic understandings of behaviour.

## Supported decision-making

Supported decision-making is a fundamental human right given effect by Article 12 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which guarantees every person's right to legal capacity – to make one's own decisions and have those decisions legally recognised. It specifically requires governments to provide people with disability the supports they may need to exercise legal capacity, meaning support for decision-making.

There is increasing evidence that the elimination of restrictive practices is contingent on people with disability having access to the supports and empowerment to exercise (and build capacity to exercise) these rights. Research commissioned by the Disability Royal Commission was clear that:

- Legal systems and service systems must facilitate autonomy
- Legislation and court jurisdictions enabling substituted decision-making must be replaced with those that are not disability-specific and additionally enable supported decision-making
- Service and health systems need to be educated and resourced to implement supported decision-making
- Systems of supported decision-making should not over-regulate the lives of people with disability.<sup>18</sup>

## Early access to communication support

Today, there are many adults and older adults with an intellectual disability with communication support needs who did not receive communication support as children or young people. This is because of what is known as the 'candidacy model', which dominated approaches to delivering communication support up until early 2000s.<sup>19</sup>

This model was based on a range of 'criteria' it was believe a person needed to fulfil to demonstrate 'candidacy' for communication support. Because of these ideas, many children with an intellectual disability were deprived of communication support based on perceptions they were "too something ... too 'young', too 'socially withdrawn', too 'intellectual disabled' or 'too linguistically delayed'".<sup>20</sup>

This model has been replaced with the 'participation model', which is a human rights- and strengths-based approach that considers all the research we have demonstrating that the use of early, ongoing communication support has a positive effect on communication abilities. This has moved practitioners away from focusing on a list of criteria to 'qualify' for access to communication support in the first instance.

This is a big shift, and it has taken place relatively recently. This means that many people with complex communication needs (especially if they are older) may have never had access to communication supports. Access to meaningful, ongoing supported decision-making is therefore extremely limited, meaning ongoing communication support is crucial for many people who are experiencing, or at risk of experiencing, restrictive practices.<sup>21</sup>

## A trauma-informed lens

The Disability Royal Commission clearly demonstrated that experiences of violence, abuse, neglect, and exploitation are frequently and disproportionately experienced by people with disability. We know that those experiences are more likely to (though do not solely) take place in segregated settings, separate from the community.<sup>22</sup> The impact and trauma caused by these experiences is enormous and can be life-long.

Becoming trauma-informed is increasingly considered good practice in a range of fields. Now that the extent of abuse and neglect experienced by people with disability has been exposed by the Royal Commission, there is an obvious need for governments and support service systems to facilitate trauma-informed approaches to delivering relevant supports.

Notably, the benefits of using a trauma-informed lens to understand behaviours – as well as trauma-informed approaches more generally – has only very recently been considered in the context of people with disability and disability services.<sup>23</sup>

Blue Knot Foundation's *Disability Guidelines for Trauma-Informed Practice*<sup>24</sup> describe a trauma-informed practice as one that:

- Is not clinical treatment
- Recognises that many issues are trauma-related and requires people to be trained to act on this awareness
- Follows the principle of 'do no harm'
- Understands the effects of stress and trauma on the brain and body
- Considers what trauma has happened to a person and not what is 'wrong' with a person
- Regards 'symptoms' as expressions of coping strategies
- Is sensitive to the person's comfort levels and to the way in which a service is delivered, not just what a service is
- Works with the person rather than doing something 'to' or 'for' the person.<sup>25</sup>

The *Disability Guidelines for Trauma-Informed Practice* also states:

*Trauma-informed support means seeing the person who has experienced trauma as the expert. It means working with a person's strengths. Not focussing on what is wrong with a person or trying to 'fix' the person. Being trauma-informed changes how we think and respond to people ... It helps us notice what is going on for someone. We can then support the person to recognise their strengths as well.*<sup>26</sup>

A trauma-informed lens may also promote deeper understandings of safety, and what makes a person feel safe or unsafe according to their unique life context. It is about understanding the way different people cope with trauma, and how trauma responses and adaptations can become barriers to connection and participation. This understanding supports those within a person's life to more meaningfully and effectively respond to a person.

## Belonging in ordinary community life

Through the thousands of testimonies of evidence given at public hearings, private sessions, community engagements, in submissions, and through its robust research program, the Disability Royal Commission showed that inclusion is most evident where:

*An individual is made welcome, where they feel welcome, where they know they belong, where they know they are safe, and where their voice is heard and acted upon ... it is where people live ... in close personal relationships with others, where they have friends and advocates and where they are free to express their philosophical/religious beliefs, sexual and cultural identities, that people can live a quality life free from violence, abuse, neglect and exploitation.*<sup>27</sup>

We refer to this as 'belonging in ordinary community life' to highlight the unremarkable yet essential human need to have access to meaningful, freely entered interpersonal connections, and the ordinariness of being in positive relationship with one's surroundings.

This is often the aim of 'informal supports' or 'natural safeguards', which are the social support networks that provide protection and support human rights by increasing connections, relationships and visibility in the wider community. They are a key preventative measure against the risks of violence, abuse, neglect and exploitation.<sup>28</sup>

Research commissioned by the Disability Royal Commission<sup>29</sup> argued that in exploring the policy and practice directions needed for people with disability to live in an inclusive society, we need to consider the ways this can and does take place through:

- Community belonging
- Visibility and feeling valued within one's community
- Unpaid, freely entered social connections.

The researchers suggested that there is a need to move beyond simplistic notions of physical location or dichotomies of inclusion versus segregation, and towards what is sometimes called 'psychological inclusion'.

This concept is aligned with our notion of 'belonging in ordinary community life' in that it focuses on the extent to which an individual perceives membership in their community, expresses an emotional connection with their neighbours, and can fulfil their needs (physical, emotional, spiritual) through community connections. This is arguably among the most poorly acknowledged in policy and most under-addressed in service and practice.

Yet that felt sense of belonging within one's community is a powerful and robust natural safeguard that prevents violence, abuse, neglect and exploitation – including those experiences which happen because of restrictive practices.

## Conclusion

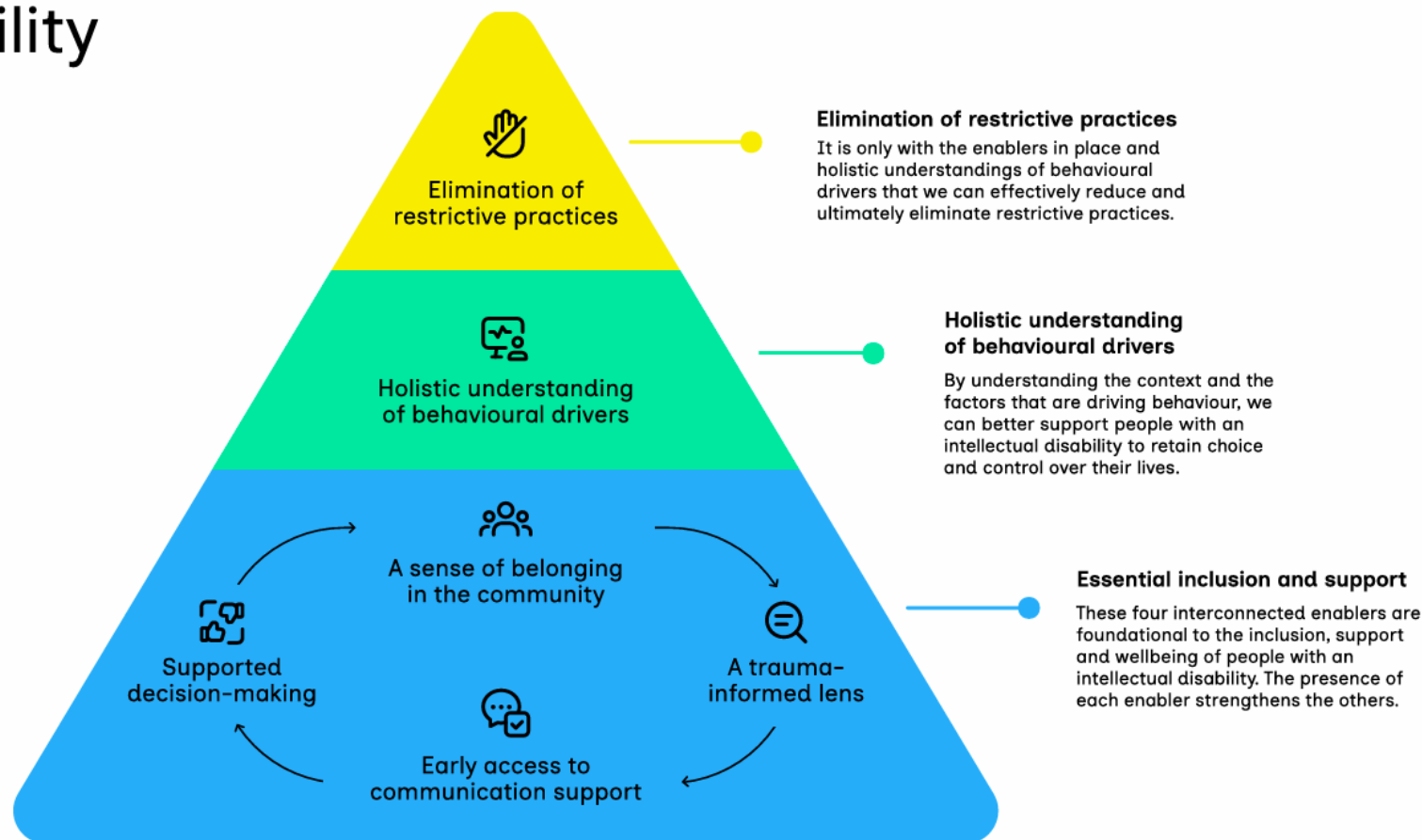
The evidence considered in this submission demonstrates that while PBS has become a widely used approach within disability service provision, its evidence base remains limited and inconclusive. Where positive outcomes are reported, they are more consistently associated with improvements in the quality of a person's environment, relationships and supports than with behavioural interventions alone.

At the same time, there is strong and growing evidence of the widespread use of restrictive practices, particularly for people with an intellectual disability and people with complex support needs. The current system settings risk reinforcing a narrow focus on behaviour and administration, rather than addressing the underlying drivers of distress, unmet need and exclusion – including through harnessing and meaningfully applying the expertise often held within families.

The experiences of people with an intellectual disability and their families highlight the importance of approaches that are relational, person-centred and grounded in a holistic understanding of behaviour. This includes recognising behaviour as communication, supporting decision-making, enabling communication needs through appropriate supports, and adopting trauma-informed approaches.

# A model for eliminating restrictive practices for people with an intellectual disability

- Enablers ● ●
- Outcome ●



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