public guardian
Queensland

Restrictive practices and secure care in Queensland's child protection system

Submission to the Child Safety Commission of Inquiry

March 2026

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About the Office of the Public Guardian

The Office of the Public Guardian (OPG) is an independent statutory office which promotes and protects the rights and interests of adults with impaired decision-making capacity and children and young people in the child protection system or staying at a visitable site.

OPG provides individual advocacy services to children and young people through the following functions:

- child advocacy, which offers person-centred advocacy for children and young people in the child protection system, and elevates the voice and participation of children and young people in decisions that affect them, and
- community visiting, which monitors and advocates for the rights of children and young people in the child protection system including kinship, foster and residential care, and all children and young people staying at visitable sites (including youth detention centres, police watch-houses and authorised inpatient mental health services). Through these functions, OPG may observe, inquire into and raise concerns regarding the use of restrictive practices affecting children and young people in these environments.

OPG provides an entirely independent voice for children and young people to raise concerns and express their views and wishes. When performing these functions, OPG will seek and take into account the views and wishes of the child or young person to the greatest practicable extent.

OPG also promotes and protects the rights and interests of adults with impaired decision-making ability through its guardianship, investigations and adult community visiting functions. This can include parents with impaired decision-making ability who may be involved in child protection matters. The *Public Guardian Act 2014* provides for the Public Guardian's legislative functions, obligations and powers relating to children and young people.

Position of the Public Guardian

The Public Guardian welcomes the opportunity to provide a submission to the Commission of Inquiry into Child Safety (the Commission) regarding restrictive practices affecting children and young people in Queensland's child protection system, including the consideration of a secure care model.

OPG's position is that subjecting children and young people to restrictive practices engages some of the most serious safeguarding and human rights concerns arising within the child protection system. These practices involve interventions that restrict a child's liberty, autonomy or freedom of movement and therefore ought to require clear legal authority, robust safeguards and independent oversight.

In Queensland, the use of restrictive practices on adults in disability service systems operate within detailed statutory authorisation and oversight frameworks. No equivalent comprehensive legislative framework currently governs restrictive practices affecting children in out-of-home care (OOHC). This contrasts with Queensland's mental health system, where restrictive practices such as seclusion and restraint are subject to explicit statutory safeguards and clinical oversight even when used with minors. This regulatory gap raises significant safeguarding concerns, particularly where highly restrictive interventions that include secluding and isolating children away from carers and the use of off-label psychotropic medications may be contemplated.

Secure care models involve the confinement of a child within a controlled environment and therefore represent one of the most restrictive interventions a child can be subject to. While secure care is typically operationalised through residential care facilities, rather than family-based or community settings, this reflects a policy and system design choice rather than an inherent feature of the intervention itself.

OPG does not support the establishment of secure care in Queensland. This position reflects both the inherent developmental, mental health and general wellbeing risks associated with confining children 24/7. Evidence from Queensland, together with experience in other jurisdictions, indicates that highly restrictive models do not consistently achieve their intended short-term stabilisation purpose and can become embedded responses to broader system pressures, particularly where therapeutic pathways, oversight mechanisms and less restrictive alternatives are limited. In these circumstances, restrictive placements may become prolonged or repeated and are unlikely to deliver the therapeutic outcomes intended for children with highly complex needs.

OPG notes that alternative models exist which seek to respond to children with complex needs without defaulting to closed or secure environments. For example, the Australian Capital Territory (ACT) has established a Therapeutic Support Panel model that integrates multidisciplinary clinical expertise, structured decision-making and, where required, judicial oversight. This model is designed to stabilise risk while maintaining a therapeutic focus and minimising the use of restrictive interventions. This provides a useful reference point for considering how Queensland might strengthen its response to children with complex needs without expanding reliance on containment-based models.

Should the Commission nevertheless consider that some form of secure intervention may be required in exceptional circumstances, OPG submits that it should be understood and regulated as an exceptional restrictive practice. Any such intervention should be tightly constrained, court-authorised, time-limited and supported by strong procedural safeguards, independent oversight and clear clinical governance.

The views expressed in this submission do not represent the views of the Queensland Government.

A summary of the Public Guardian's recommendations appears below:

RECOMMENDATIONS OF THE PUBLIC GUARDIAN:

1. System-level evidence and visibility
Establish an independent investigation into the prevalence, nature and drivers of restrictive practices affecting children and young people in residential care.
This should include:

- analysis of available datasets, behaviour support planning and the use of each category of restrictive practice
- demographic and cohort characteristics, including age, gender identity, disability, communication needs, First Nations status and cultural and linguistic diversity

2. Ongoing data transparency and reporting
Establish a minimum dataset and public reporting framework for restrictive practices affecting children and young people, including:

- frequency, type and duration of restrictive practices
- use of emergency responses
- demographic characteristics of affected children
- outcomes and pathways following intervention

This should support transparency, accountability and ongoing evaluation of system performance.

3. Workforce capability and practice reform
Implement a mandatory workforce capability framework for staff supporting children and young people in residential care, including:

- training in disability, trauma-informed practice and positive behaviour support
- skill development in de-escalation and therapeutic engagement
- capability to identify and appropriately respond to restrictive practices

This should support a shift away from reactive and restrictive responses toward therapeutic, evidence-based practice.

4. Whole-of-system legislative framework

Adopt a consistent, cross-sector legislative framework governing restrictive practices across disability, child protection and health systems, applicable to all persons regardless of age.

This framework should:

- clearly define restrictive practices
- require evidence-based positive behaviour support
- ensure consistent safeguards, authorisation processes and accountability mechanisms across systems

5. Distinction between restrictive practices and deprivation of liberty

Ensure that legislation clearly distinguishes between:

- restrictive practices used within care and support settings, and
- interventions that constitute a deprivation of liberty through confinement in a closed environment

This distinction should be reflected in escalating thresholds, safeguards and authorisation pathways.

6. Independent clinical authorisation and practice leadership

Establish an independent statutory office holder (such as an Office of a Senior Practitioner), operating outside of Child Safety and service delivery systems, to:

- authorise the use of restrictive practices affecting children
- oversee the application of best practice in reducing and eliminating restrictive practices
- provide clinical leadership, guidance and sector-wide capability development

This function should apply across all relevant service systems and include oversight of environmental restrictions and other non-obvious restrictive practices.

7. Alternative model to secure care (therapeutic/clinical decision-making model)

Do not establish a facility-based secure care model in Queensland. Instead, adopt a multidisciplinary, clinical decision-making model (such as the ACT Therapeutic Support Panel framework) which:

- coordinates cross-agency clinical and therapeutic responses
- embeds decision-making authority across child protection, health and disability systems
- requires that less restrictive alternatives are actively explored and exhausted
- enables time-limited containment interventions only where necessary
- operates under independent authorisation and judicial oversight
- provides a structured mechanism for responding to acute risk without reliance on institutional secure care environments.

8. Judicial authorisation of deprivation of liberty

Require that any intervention involving the confinement of a child or young person in a closed environment be subject to independent judicial authorisation and review.

This should:

- recognise deprivation of liberty as a distinct and highly restrictive intervention
- ensure necessity and proportionality are independently tested
- include time limits and regular review mechanisms

9. Independent systemic advocacy and oversight for children with impairment
Establish or expand an independent statutory function (such as the Public Advocate or equivalent) to provide systemic advocacy and oversight for children and young people with impaired capacity.
This function should provide:

- independent, system-level advocacy
- specialist expertise in impaired capacity
- oversight of how restrictive practices are applied to this cohort across systems

Overview of restrictive practices

A restrictive practice is any practice or intervention that restricts a person's rights, liberty or freedom of movement. These practices are typically used to control or manage behaviour that presents harm to the person or others, rather than to treat a medical condition, manage a perceived community safety issue, or provide therapeutic support. Behaviours of harm should be evidenced and not based on theoretical risk of harm. Restrictive practices include seclusion, physical restraint, chemical restraint (the use of medication to control behaviour), mechanical restraint and environmental restrictions (containment) such as locking doors, limiting a person's access to parts of their environment or limiting their access to objects such as food in the fridge or the television remote. At the most restrictive end of this spectrum are practices that prevent a person from leaving a placement altogether, sometimes at the same time as isolating and secluding them away from carers.

Restrictive practices are most commonly discussed in disability service contexts, where they are often used in conjunction with positive behaviour support to respond to behaviours that may cause harm to a person or others. However, such practices also arise in other care environments, including child protection settings.

The examples below demonstrate what the use of regulated restrictive practices with children and young people with disability could look like. However, determining whether a regulated restrictive practice is the least restrictive option possible and proportionate to the potential risk of harm needs to be made on a case-by-case basis, and in the context of a positive behaviour support framework, which promotes the child's development and their right to take reasonable risks (i.e., dignity of risk).

Not a Restrictive Practice	Regulated Restrictive Practice
Using hand over hand physical guidance to teach a child or young person a new skill	Using physical force to pull a young person in a direction they do not want to go (physical restraint)
Holding a child's hand while crossing the road	Using a two person escort to prevent a young person's movement during an outing (physical restraint)
Using a splint to treat a sprained wrist consistent with doctor's recommendations	Using a splint to prevent a child or young person from hitting themselves or self-injuring (mechanical restraint)
Using a pram to prevent a three year old from running away at the doctors	Using a wheelchair to prevent a 10 year old child who is ambulant from running away at the doctors (mechanical restraint)

Not a Restrictive Practice	Regulated Restrictive Practice
Using child gates to prevent a toddler or child from falling down stairs	Using child gates to prevent a young person entering a room or a child being confined in a space where voluntary exit is prevented (environmental restraint or seclusion)
Using a child gate to prevent a toddler from accessing the kitchen while the stove / oven is in use	Using a child gate to prevent a young person from accessing the kitchen at all times (environmental restraint)
Restricting a toddler or younger child's access to sharps or matches	Restricting access to sharps for a young person who is developing their knife and cooking skills following a behavioural incident (environmental restraint)
Locking the front door to prevent a toddler or young child leaving on their own	Deadlocking the front door during the day to prevent a young person from leaving the house (environmental restraint; also a fire safety issue); or Locking the fridge and pantry to prevent a child or young person from accessing food (environmental restraint)
Mounting a TV to a wall or enclosing it in a TV cabinet with free access to remotes	Mounting a TV to a wall or enclosing it in a TV cabinet and locking away the remote (environmental restraint)
Using bed rails when transitioning a toddler from a cot to a bed	Using a cot style bed to prevent a child or young person them from getting out of bed (environmental restraint or seclusion)
A parent deciding they do not want their child or young person to have a mobile phone	An NDIS provider locking away a child or young person's mobile phone and access being contingent on behaviour (environmental restraint)
A young person (over the age of consent) requesting to take the contraceptive pill	Using medication for menstrual suppression for convenience or hygiene reasons (without the young person having any choice or control); or using medication with sedative quality for aggression (chemical restraint)
Using a child car restraint with a child under the age of 7	Using a harness with a 12 year old to prevent them hitting others whilst in transit (mechanical restraint)
A child being briefly unattended in a safe environment (e.g., for periods of <10mins) while their parent or carer is in the bathroom or another room but within hearing distance of the child	Confining a child or young person (on their own) in a locked house or in a locked room of a house or being locked alone in a vehicle (seclusion)

The use of restrictive practices represents a significant interference with a person's fundamental human and legal rights. For this reason, restrictive practices are generally recognised in law and policy as measures of last resort that require strong statutory or court imposed safeguards, oversight and clear justification.

International human rights frameworks recognise the seriousness of restricting liberty. The *United Nations Convention on the Rights of the Child* provides that children must not be deprived of their liberty unlawfully or arbitrarily and that detention must occur only as a measure of last resort and for the shortest appropriate period of time. Article 14 of the *Convention on the Rights of Persons with Disabilities* similarly provides that the existence of a disability must in no case justify a deprivation of liberty. The High Court of Australia has also recognised that the right to personal liberty is "the most elementary and important of all common law rights".[i]

The primary purpose of restrictive practices should be to protect the person, or others, from actual harm. Evidence-based positive behaviour support practices, that includes skills development, must be used in conjunction with the use of any restrictive practice to reduce and eliminate the need for restrictive practices where possible. Restrictive practices should only be used as a last resort and be the least restrictive option available. Their use should be time limited and accompanied by a plan to reduce and ultimately eliminate reliance on the practice.

Restrictive practices affecting children are treated with particular caution in other service systems. In Queensland's mental health system, practices such as seclusion and physical restraint are governed by detailed statutory and clinical safeguards under the *Mental Health Act 2016* and associated Chief Psychiatrist policies.[ii] These provisions apply equally to adults and minors who are subject to treatment authorities or forensic orders. Importantly, clinical guidance accompanying these provisions recognises that the use of seclusion or restraint may expose children and young people to significant psychological trauma and requires that staff involved are aware of this heightened vulnerability. By contrast, comparable restrictive practices affecting children in OOHC are not currently governed by an equivalent statutory authorisation and oversight framework.

More broadly in Queensland, the use of restrictive practices on adults with intellectual or cognitive disability, that receive state or NDIS funded supports, is subject to strict regulation, monitoring and oversight through an authorisation framework under the *Disability Services Act 2006* and the *Guardianship and Administration Act 2000*. There is no equivalent authorisation framework for children in Queensland, whether or not they have a disability.

For both children and adults receiving supports funded by the *National Disability Insurance Scheme* (NDIS), there is some regulation of restrictive practices used by registered service providers by the NDIS Quality and Safeguards Commission (NDIS Commission). Providers must be registered and comply with the *NDIS (Restrictive Practices and Behaviour Support) Rules 2018* (NDIS Rules), which require behaviour support planning, monitoring and reporting of restrictive practices. However, these rules do not themselves authorise restrictive practices. Instead, the NDIS Rules specify that the use of restrictive practices must be authorised in accordance with the relevant state or territory's authorisation process.[iii] If the relevant state or territory does not have an authorisation process, NDIS service providers must still comply with the Rules.

While the NDIS framework provides some oversight where children with disability receive NDIS-funded supports, OPG has observed that the broader use of restrictive practices affecting children and young people in residential care and other service settings in Queensland is not subject to the same statutory authorisation and oversight

[i] *Trobridge v Hardy* (1955) 94 CLR 147, 152.
[ii] **Treatment and care of minors**
[iii] *NDIS (Restrictive Practices and Behaviour Support) Rules 2018*, r.9.

framework that applies to adults. Even if children in OOHC are NDIS participants, many currently fall outside of the NDIS regulated framework as their primary care is from residential care providers who are not funded disability support providers and are instead funded by Child Safety.

Human rights considerations

Restrictive practices must be considered in the context of human rights protections. The use of restrictive practices must only occur where compatible with human rights, as defined in the *Human Rights Act 2019*. Many children, young people and adults who are subject to the use of restrictive practices are extremely vulnerable to human rights abuse.

Unauthorised, or excessive use of restrictive practices is a significant concern for the Public Guardian, given that the application of restrictive practices represents one of the greatest potential infringements of human rights. Therefore, monitoring and advocacy in relation to the use of restrictive practices remains one of the Public Guardian's priorities.

The Charter of Rights for a child in care under the *Child Protection Act 1999* recognises that children in the child protection system have the right to a safe and stable living environment and to be placed in care that best meets their needs and is culturally appropriate.[iv] Article 23 of the *United Nations Convention on the Rights of the Child* also recognises that children with disability are entitled to special care and support so that they can live a full and independent life. The current residential models available for care for children and young people with disability in Queensland risk falling short of this obligation.

Ensuring that restrictive practices are subject to appropriate safeguards and oversight is therefore an important component of protecting the rights and wellbeing of vulnerable children and young people.

Impact on children and young people in care

Children and young people in out-of-home care frequently have complex needs that must be met to ensure their safety and wellbeing. Many children who come into contact with the child protection system have experienced significant disadvantage, including abuse, neglect, family instability or exposure to violence. They are also more likely to live with disability and to have experienced complex trauma.

These experiences mean that children in care may be particularly vulnerable to the impacts of restrictive practices. Practices such as restraint, seclusion and environmental restrictions can negatively affect a child's sense of safety, attachment and relationships, and is highly likely to escalate distress and behavioural responses rather than resolving them[v]. The use of restrictive practices means any concerns about behaviours of harm becomes a self-fulfilling prophecy as the restrictions result in escalated behaviours that cause harm, thus justifying the continued or increased use of more restrictive practices. Research also indicates that these interventions can undermine self-esteem and mental health and may be experienced by children as punitive or harmful, particularly where they have previously experienced violence or degradation[vi]. These dynamics can contribute to placement instability and further disruption in a child or young person's care environment. In institutional or closed settings, the impacts may be compounded where children are separated from family, peers, community and education and exposed to additional coercive interventions.

[iv] *Child Protection Act 1999*, section 74 and Schedule 1.

[v] Crowe, Kate. 2025. Secure CareinAustralia—AnOverviewof Secure CareinAustralianStates and Territories and Commentaryonthe Legal Safety of ChildrenAdmittedto Secure CareinAustralia. Social Sciences 14: 550. https://doi.org/ 10.3390/socsci14090550

[vi] Crowe, Kate. 2025. Secure CareinAustralia—AnOverviewof Secure CareinAustralianStates and Territories and Commentaryonthe Legal Safety of ChildrenAdmittedto Secure CareinAustralia. Social Sciences 14: 550. https://doi.org/ 10.3390/socsci14090550

The Disability Royal Commission (DRC) further emphasised that behaviours of concern are often a form of communication, particularly for children and young people with intellectual disability or cognitive impairment, and may reflect unmet need, distress or trauma rather than wilful non-compliance. The DRC observed that where these behaviours are pathologised rather than understood, restrictive practices may be used to 'manage' behaviour instead of addressing its underlying cause[vii]. It also identified that the use of restrictive practices can have harmful and, in some cases, lifelong impacts on children and young people[viii]. While not all children in residential care have a diagnosed disability, the high prevalence of cognitive impairment, neurodevelopmental conditions and trauma within this cohort means these dynamics are highly relevant in the child protection context.

These risks are particularly acute for Aboriginal and Torres Strait Islander children and young people, who are significantly overrepresented in OOHC and residential care settings. The use of restrictive practices in these contexts may intersect with experiences of intergenerational trauma, including the legacy of forced removal, institutionalisation and disconnection from family, community and Country. The application of restrictive interventions in the absence of culturally informed, trauma and disability responsive approaches may exacerbate distress, undermine cultural identity and trust, and contribute to further disengagement from supports. Language and communication differences may also affect a child's ability to understand or respond to restrictive interventions, increasing the risk of escalation and misinterpretation of behaviour.

Evidence from disability and behaviour support frameworks identifies a range of harms associated with the use of restrictive practices on children and young people. These practices may inhibit skill development, contribute to trauma and psychological harm, damage relationships between children and those supporting them, and in many cases escalate behaviours of concern rather than addressing their underlying causes.[ix] Restrictive practices also carry risks of physical injury and, in rare but documented circumstances, catastrophic outcomes including death. As a result, contemporary regulatory frameworks emphasise that restrictive practices should only be used as a last resort, must be proportionate to risk, and should be reduced and eliminated over time through the use of positive behaviour support and other therapeutic approaches.[x]

While there has been a societal emphasis on reducing and avoiding physical restraint, this shift in practice may also give rise to unintended consequences in residential care settings. Where staff consider they have limited authority to use physical intervention, even in circumstances of escalating risk, there may be increased reliance on external emergency responses, including police attendance, to manage behaviours of concern. At the same time, restrictive responses may shift toward environmental controls, including restricting a child's access within their placement, secluding them in their room (isolation) and limitations on movement, social interaction and community access. While these approaches may be perceived as less physically intrusive, they can involve sustained restrictions on liberty and have significant psychological impacts. Evidence from youth detention and institutional settings indicates that prolonged isolation and seclusion can contribute to distress, behavioural escalation and longer-term impacts on mental health and development.[xi]

The risks highlight the importance of strong governance arrangements to ensure restrictive practices affecting children are used only as a last resort and are subject to independent authorisation and oversight. Reducing reliance on restrictive practices therefore requires a strong focus on trauma-informed practice and an improved understanding of the context in which a child or young person's behaviours occur. For Aboriginal and Torres Strait Islander children, responses to behaviours of concern must be culturally safe, grounded in connection to family

[vii] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Final Report* (2023) vol 6, p.467
[viii] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Restrictive Practices Issues Paper* (2020), p.4
[ix] NDIS Quality and Safeguards Commission, *Regulated Restrictive Practices with Children and Young People with Disability* (2022)
[x] NDIS Quality and Safeguards Commission, *Regulated Restrictive Practices with Children and Young People with Disability* (2022)
[xi] Australian Human Rights Commission, *'Left Alone': A Review of Solitary Confinement and Similar Practices in Australia's Youth Justice Systems* (2025)

and community, and informed by an understanding of the broader historical and social context in which these children experience care. Care providers must be supported to identify and implement alternative responses that prioritise therapeutic engagement, positive behaviour support and de-escalation strategies.

Restrictive practices framework for adults

Queensland has established a statutory framework regulating the use of restrictive practices for adults with intellectual or cognitive disability that receive state or NDIS funded disability support. This framework operates under the *Disability Services Act 2006* and the *Guardianship and Administration Act 2000*.

Prior to the introduction of this statutory regime, the use of restrictive practices in the Queensland disability sector was self-regulated and subject to misuse. Reviews of the sector identified the need for legislative oversight to ensure restrictive practices were subject to appropriate safeguards and independent scrutiny.[xii] This led to implementation of the strong regulatory regime which now oversees the authorisation of restrictive practices in most disability support settings in Queensland. This regime provides a process for the consideration of requests from relevant service providers to use restrictive practices, which may otherwise amount to actions that may constitute an assault or other criminal offence against the adult.

The *Disability Services Act 2006* states that when restrictive practices are proposed, they must be used in a way that:[xiii]

- has regard for the human rights of those adults
- safeguards them and others from harm
- maximises the opportunity for positive outcomes and aims
- reduces or eliminates the need for the use of the restrictive practice
- ensures transparency and accountability in the use of the restrictive practices.

Pursuant to the *Disability Services Act 2006*, a restrictive practice may only be authorised as part of a planned response to an adult's behaviour that causes harm where it has been demonstrated that such a response is the least restrictive way of ensuring the safety of the adult or others. The *Disability Services Act 2006 also* requires that a relevant service provider undertakes appropriate assessment and develops a positive behaviour support plan (PBSP).

A key safeguard of the *Disability Services Act 2006* is the requirement that funded disability service providers must seek authorisation from the relevant independent body or person prior to the use of the restrictive practice where a state authorisation is available. The *Disability Services Act 2006* safeguards the human rights of people with an intellectual or cognitive disability from the inappropriate use of restrictive practices. It also provides an accountability framework that allows for transparency in the decision-making process to authorise or decline requests to use a restrictive practice.

Intersection with the NDIS

Despite the existence of this comprehensive framework for adults with intellectual or cognitive disability, there is currently no equivalent statutory authorisation framework governing the use of restrictive practices for children and young people in Queensland.

[xii] Hon. W. J. Carter QC, Report to Honourable Warren Pitt MP, Minister for Communities Disability Services and Seniors, *Challenging Behaviour and Disability: A Targeted Response* (2006).
[xiii] *Disability Services Act 2006*, s.139.

The Queensland restrictive practices authorisation framework interacts with the national NDIS regulatory framework for adult participants receiving funded support from NDIS service providers and these registered NDIS providers in Queensland are required to comply with the NDIS Rules. The NDIS Rules set out conditions of registration that apply to all registered NDIS providers who use regulated restrictive practices in the course of delivering NDIS supports or services to a person with disability. This includes an adult or child with any type of disability who receives NDIS supports or services from a registered NDIS provider.

For people who are participants of the NDIS, setting standards for, and training of registered NDIS providers using restrictive practices under a participant's NDIS plan, is the responsibility of the NDIS Commission. Where a registered NDIS provider does not have to seek authorisation to use restrictive practices, they must still develop a behaviour support plan and report on the use of restrictive practices to the NDIS Commission if they are using regulated restrictive practices under the NDIS Rules. This is the case for children and young people with disability in Queensland who receive NDIS supports or services. The NDIS Commission is the national regulator responsible for oversight of the use of restrictive practices in the provision of services to people that receive funded support from NDIS service providers, including children. However, a large group of children and young people in OOHC with and without NDIS plans fall outside of the NDIS regulatory framework as their primary supports and services are provided by carers funded by Child Safety and not disability agencies. Often their NDIS plans are limited to funding services from behaviour support practitioners to author Behaviour Support Plans, or allied health professionals.

Unregulated use of restrictive practices on children and young people in care

Queensland has one of the country's most robust frameworks for the authorisation of restrictive practices for adults with an intellectual or cognitive disability receiving specialised disability services or NDIS funded supports or services under the *Disability Services Act 2006*.

There is no equivalent independent authorisation framework in Queensland for the use of restrictive practices on children and young people, whether or not they have a disability.[xiv]

The lack of lawful authorisation or robust regulation and oversight of the use of restrictive practices on children and young people has been a longstanding concern for OPG. An area of significant concern is the use of practices on children and young people in residential care settings that would meet the definition of restrictive practices in both state and national legislation, including seclusion, containment (environmental restraint), and chemical, physical and mechanical restraint. In the absence of a legislative authorisation regime for people under 18 years of age in residential care, which is comparable to other existing regimes for adults, these children and young people are at risk of being subjected to unauthorised restrictive practices.

The use of restrictive practices in residential care is subject to the *Child Protection Act 1999*, the ***Department of Families, Seniors, Disability and Child Safety (Child Safety) Positive behaviour support policy no. 604-5*** and ***Managing high risk behaviour policy no. 646-2***.

Child Safety's *Positive behaviour support policy 604-5* provides that the following interventions are prohibited practices, being unlawful and unethical practices which present a high risk of causing high level discomfort and trauma:

- corporal punishment
- unethical practices to modify a child or young person's behaviour

[xiv] The *Mental Health Act 2016* provides a framework for the use of restrictive practices on patients in authorised mental health services, including children and young people.

- planned use of physical restraint
- planned use of restriction of access to items (environmental restraint)
- containment (environmental restraint)
- seclusion
- chemical restraint
- mechanical restraint, and
- aversive strategies.

The policy further provides that prohibited practices must not be used in responding to the behaviour of children who are placed in care under section 82(1) of the *Child Protection Act 1999*.

Child Safety's *Managing high risk behaviour policy* provides that children and young people have the right to protection from prohibited practices while being supported to develop positive behaviours. It reiterates the above information from the *Positive behaviour support policy*.

Despite Child Safety's policy position which prohibits the use of restrictive practices, OPG is aware that children in residential care are subject to restrictive practices. Therefore, this framework is not sufficiently robust, or effective in preventing the use of restrictive practices on children and young people in residential care, particularly the use of behaviour modifying medication for children with a disability diagnosis, which would otherwise constitute chemical restraint under the authorisation framework for adults.

A review of issues raised by OPG's community visitors since 1 January 2025 to 1 March 2026 indicates possible instances of practices that may constitute restrictive practices in residential care. Themes include:

- 24/7 containment and instances of seclusion (isolation)
- locked gates, doors and windows
- restricted access to objects, and
- chemical restraint.

Due to the current policy position held by Child Safety in relation to the management of high-risk behaviours and positive behaviour support, planned restrictive practices are not allowed under departmental policy. However, Child Safety may rely on separate internal processes when seeking to implement or consent to practices that fall outside the parameters of Child Safety Policy No 604-4: *Positive Behaviour Support* and Child Safety Policy No 646-1: *Managing High Risk Behaviour*. This creates ambiguity regarding when restrictive practices are being used in residential care and the legal and administrative mechanisms through which they are authorised.

There is no reporting on restrictive practices and therefore no public accountability or transparency. Consequently, the prevalence of restrictive practices is unknown, and any available data would not be accurate as there is no legislative framework or common understanding of what restrictive practices are in the child protection sector. As a result, it is difficult for OPG, as an oversight agency safeguarding the rights and interests of children in OOHC, to clearly identify when regulated restrictive practices are occurring or when concerns should be raised with Child Safety or the NDIS Commission. The number of children and young people in Queensland who are subject to restrictive practices in residential care needs to be publicly available for transparency and accountability, as well as comprehensive data around its use.

From time to time, OPG's community visitors are alerted to or make observations during visits of practices that may reflect the planned use of regulated restrictive practices.

Case example: Tara*

Tara is a 15-year-old female young person with a primary diagnosis of Vulto-van Silfhout-de Vries Syndrome (VS-VS) and Autism Spectrum Disorder (ASD) level 3. She lives in residential care with a registered NDIS provider and receives behaviour support services from another registered NDIS provider. The specialist behaviour support provider must comply with the NDIS Rules in undertaking a behaviour support assessment and developing a behaviour support plan for Tara that contains regulated restrictive practices. The other registered NDIS provider must also comply with the NDIS Rules and the behaviour support plan where they may implement regulated restrictive practices in the course of delivering NDIS-funded supports and services to Tara.

Tara is subject to several interventions that would meet the definition of restrictive practices under the authorisation framework that applies to adults, including chemical restraint and environmental restrictions such as locked gates, doors and windows at the placement. Under Child Safety policy, the use of restrictive practices for children in care, including chemical restraint, is a prohibited practice. However, because no statutory authorisation framework exists for restrictive practices affecting children in residential care, practices that may amount to restrictive practices can still arise without independent authorisation or clear external oversight.

OPG has observed a level of reliance on emergency service responses during behavioural escalations, resulting in Tara being subjected to the use of force by the Queensland Police Service and chemical restraint administered by the Queensland Ambulance Service or Queensland Health during transport to hospital. These responses occur in addition to the restrictions present within the day-to-day placement environment.

While Tara's positive behaviour support plan seeks to reduce reliance on emergency service responses, the case illustrates the practical challenges that arise where restrictive practices affecting children occur in the absence of a clear statutory authorisation and oversight framework.

**Name has been changed*

RECOMMENDATION: OPG recommends that the Commission of Inquiry should recommend that there is an independent investigation into the prevalence of the use of restrictive practices on children and young people in residential care. This could include potential datasets identified in the Child Safety policies, data about behaviour support plans, use of each type of restrictive practices, and demographics of the children and young people in residential care who are subject to the use of restrictive practices, including age, gender identity, disability, communication method, First Nations status, or CALD status.

RECOMMENDATION: OPG recommends that a minimum dataset and public reporting framework be established for restrictive practices affecting children and young people. This should include:

- frequency, type and duration of restrictive practices
- use of emergency responses
- demographic characteristics of affected children
- outcomes and pathways following intervention

This would support transparency, accountability and ongoing evaluation of system performance.

Chemical restraint on children and young people in residential care

OPG is concerned that the use of restrictive practices, in particular the administration of behavioural medication on children and young people in residential care, is not subject to adequate regulation and safeguards under the *Child Protection Act 1999*. The use of chemical restraint is a prohibited practice for children in the care of Child Safety, as outlined in the *Child Safety Policy No 604-4: Positive Behaviour Support* and *Child Safety Policy No 646-1: Managing High Risk Behaviour*. However, OPG is concerned that children and young people may be subjected to the use of behaviour modifying medications while in care, and this may occur without an appropriate diagnosis. OPG is aware of allegations that these medications may be sought to make trauma or distress related behaviours easier to manage, without the implementation of positive behaviour support or regard to the potential implications to the developing brain or the rights of the child or young person.

OPG has anecdotal information that some residential care facilities may seek out doctors who will provide prescriptions for medication for the purpose of managing behaviour. In addition, OPG has observed cases where medications appear to have been administered to children in care for purposes other than the child's medical treatment or health care. OPG is also aware of allegations that a child or young person's placement may be at risk if the service is not able to use these medications. There is no formal data available to substantiate or quantify this anecdotal information. Accordingly, greater transparency is needed from residential care providers and Child Safety to monitor the use of behaviour modifying medication on children and young people in care.

As seen in the aged care sector, without an appropriate regulatory scheme, there is a significant risk that such medication will be used in place of proper carer or staff training or resourcing. The use of medication intended to manage behaviour (often psychotropic medication) can have serious side effects and implications in terms of a child's development and well-being.

Child Safety policy[xv] provides that the use of medication for the primary purpose of managing a child or young person's behaviour constitutes chemical restraint and is a prohibited practice when responding to behaviour in care placements. However, OPG remains concerned that medications used to manage behaviour are still being prescribed or administered in practice, and that their use is not subject to the same statutory authorisation and oversight framework that applies to restrictive practices affecting adults.

Community visitors visit children who are prescribed behaviour modifying medications and will make enquiries, raise issues regarding the mental health diagnosis and consent to administer the medication, access to mental health services and support, and positive behaviour support where necessary. Community visitors have observed residential care workers who appear to lack an understanding of what restrictive practices are. For example, carer ss may advise that there are no restrictive practices in use, but when the community visitor reviews the Clarification of Purpose of Medication Form, it shows that medications are prescribed for controlling behaviour.

There is a lack of training in restrictive practices, including the use of positive behaviour support strategies to re-direct a situation and address the child's communication needs in a positive manner. In the absence of this training to utilise positive behaviour support and skills development, a child's behaviours are unlikely to change which then leads to the ongoing, or increased use of restrictive practices. OPG therefore suggests that there needs to be mandatory training for residential care workers to understand and identify the use of restrictive practices. OPG also proposes that behaviour support plan training needs to be prioritised for all carers when a new behaviour support plan is developed. Staff need to be trained in working with children and young people

[xv] Department of Families, Seniors, Disability Services and Child Safety, *Managing High Risk Behaviour* (Policy No 646-1 / 646-2), definition of "chemical restraint"

with complex needs, including histories of trauma, mental health issues, drug and alcohol misuse, physical and intellectual disabilities, and developmental disorders. OPG strongly recommends a move away from reactive, community justice response models for children who engage in behaviours that may cause harm and encourages investment in specialised clinical service provision and targeted delivery to prevent and address the challenging behaviours that may be exhibited by children and young people. In the absence of such supports, these children and young people can be subjected to restrictive practices indefinitely.

RECOMMENDATION: OPG recommends the implementation of a mandatory workforce capability framework for staff supporting children and young people in residential care, including:

- training in disability, trauma-informed practice and positive behaviour support
- skill development in de-escalation and therapeutic engagement
- capability to identify and appropriately respond to restrictive practices

This should support a shift away from reactive and restrictive responses toward therapeutic, evidence-based practice.

Need for a uniform restrictive practices authorisation framework

Consideration should be given to adopting a legislative scheme that would ensure consistent independent authorisation of the use of restrictive practices across Queensland. This framework should apply across all sectors in which restrictive practices are used, including disability, child protection and health, and to all persons regardless of age, to provide consistent safeguards, monitoring and oversight. The legislation should clearly define and limit the use of restrictive practices, require evidence-based positive behaviour support, and include appropriate penalties for misuse or unlawful application.

A key feature of such a framework would be the establishment of an independent authorisation function, such as an Office of a Senior Practitioner, to oversee the use of restrictive practices and promote best practice in their reduction and elimination. This function would apply to restrictive practices used in day-to-day care and support settings, including environmental restrictions.

However, where interventions extend beyond restrictive practices to the deprivation of liberty through containment in a closed environment, a higher threshold of independent authorisation is required. Decisions of this nature should not be authorised through an administrative or clinical process alone, but should be subject to independent judicial oversight.

In this context, OPG considers that any model involving the confinement of a child should be authorised and reviewed by a court and embedded within a structured therapeutic decision-making framework. The approach adopted in the Australian Capital Territory (discussed in the interjurisdictional comparison section of this submission) provides a relevant example, where the Therapeutic Support Panel coordinates multidisciplinary assessment and ensures that less restrictive options are exhausted before any containment intervention is considered, with ultimate authorisation provided through court processes.

The adoption of a uniform framework that distinguishes between restrictive practices and deprivation of liberty would provide greater clarity, consistency and protection of rights across service systems, while ensuring that the most restrictive interventions are subject to the highest level of independent scrutiny.

RECOMMENDATION: OPG recommends the adoption of a consistent, cross-sector legislative framework governing restrictive practices across disability, child protection and health systems, applicable to all persons regardless of age. This framework should:

- clearly define restrictive practices
- require evidence-based positive behaviour support
- ensure consistent safeguards, authorisation processes and accountability mechanisms across systems

RECOMMENDATION: OPG recommends that legislation clearly distinguish between:

- restrictive practices used within care and support settings, and
- interventions that constitute a deprivation of liberty through confinement in a closed environment

This distinction should be reflected in escalating thresholds, safeguards and authorisation pathways.

Independence in decision making

Best practice decision making about restrictive practices requires complete independence from the service provider and clinical expertise in understanding positive behaviour support, responding to behaviours of harm as a method of communication, and developing effective reduction and elimination strategies. In 2020, Griffith University undertook an independent review of Queensland's restrictive practices framework for adults on behalf of Disability Services and the former Department of Justice and Attorney-General.[xvi] The purpose of the independent review was to consider opportunities for greater alignment with the NDIS Quality and Safeguarding Framework and national principles regarding restrictive practices. Among other things, the review found that there is a potential conflict of interest in guardians making decisions about restrictive practices when their role is to protect the rights of the person. This conflict of interest would also exist for Child Safety as corporate parent.

Where medication is prescribed for the purpose of modifying behaviour, the medical professional who prescribes the medication is not the decision maker for providing authorisation or consent for the medication to be used. This responsibility sits with the person who has decision-making authority for the child or young person.

The decision to authorise the use of restrictive practices should not be made by Child Safety or carers, who may also have a clear interest in regulating a person's behaviour which may conflict with the person's individual rights and interests. A properly resourced, skilled, independent, and impartial judicial body or independent statutory office holder should be legislatively empowered to examine the circumstances surrounding a request for the use of restrictive practices, authorise or decline requests to use, and monitor the use to ensure that a positive behaviour plan is in place and that progress is being made towards reducing and eliminating the use of restrictive practices.

Establishment of an independent office holder, such as an Office of a Senior Practitioner, could also assist in providing advice and training to the sector. Any such role should be established as an independent statutory function operating outside of Child Safety and service delivery systems, rather than as an internal operational role. This would enable a person with clinical and practical expertise to oversee and encourage implementation of best practice in reducing and eliminating the use of restrictive practices. It is also essential that the recruitment and development of suitably qualified allied health and other support staff and their ongoing training and personal development are a high priority within this sector so that staff know and implement best practice with respect to children and young people with challenging behaviour.

[xvi] Griffith University, *Final Report: Independent review of Queensland's regulatory framework for positive behaviour support and restrictive practices* (2020)

RECOMMENDATION: OPG recommends that consideration be given to establishing an independent statutory office holder (such as an Office of a Senior Practitioner), operating outside of Child Safety and service delivery systems, to:

- authorise the use of restrictive practices affecting children
- oversee the application of best practice in reducing and eliminating restrictive practices
- provide clinical leadership, guidance and sector-wide capability development

This function should apply across all relevant service systems and include oversight of environmental restrictions and other non-obvious restrictive practices.

Secure care as a restrictive intervention in the child protection system

Secure care proposals arise within the broader context of restrictive practices affecting children and young people in the child protection system. A secure care model would authorise the confinement of a child, presumably within a residential environment and would represent the most restrictive forms of intervention available. Consideration of secure care is therefore closely connected to the governance of restrictive practices more broadly, including questions of authorisation, oversight and safeguards.

Secure care generally refers to a model in which a child is placed in a residential environment where their freedom of movement is restricted to manage risk. It is generally used for a small cohort of children and young people already involved in statutory child protection processes, most commonly those living in residential care. These children and young people often present with complex trauma histories, behavioural dysregulation and co-occurring mental health, or neurodevelopmental disorders such as Foetal Alcohol Syndrome Disorder or Autism Spectrum Disorder. Their needs may exceed the capacity of standard residential placements while not meeting statutory thresholds for involuntary admission under mental health legislation. Some may only have a disability diagnosis and no mental health diagnosis.

Secure care is typically framed as a short-term stabilisation intervention intended to manage immediate risk while assessment and treatment planning occur. However, its role within child protection systems remains contested. Reviews in several jurisdictions have observed that proposals for secure care often emerge when service systems struggle to support a small group of highly complex children and young people through existing therapeutic and placement pathways. As a result, discussions about secure care frequently focus not only on the intervention itself, but on the broader governance, safeguards and service system conditions in which it operates.

Queensland child protection context and safeguarding considerations

Proposals for secure care in Queensland arise within a child protection system already responding to a cohort of children and young people with highly complex behavioural, developmental, disability and mental health needs. The safeguarding implications of introducing such an intervention must therefore be assessed against the characteristics of this cohort and the current service landscape in which they are supported.

Concentration of complexity within residential care

Discussions of secure care most often relate to the group of children and young people residing in residential care. In Queensland, residential care is increasingly used to support children and young people with highly complex needs, including significant trauma histories, behavioural dysregulation and co-occurring mental health and disability.

National reporting indicates the extent to which mental health need is concentrated within residential care settings. Queensland data shows that for children and young people in residential care, 51% have a diagnosed or

suspected disability while 40% have a diagnosed or suspected mental illness.[xvii] These figures demonstrate that the cohort under consideration is already concentrated in the most intensive parts of the child protection system. However, research suggests that disability and neurodevelopmental conditions are frequently under-identified among children and young people in OOHC care due to delayed assessment, diagnostic complexity, fragmented service involvement, and inconsistent definitions.[xviii] As a result, the prevalence of disability within residential care populations is likely to be significantly higher than reporting suggests.

A further consideration is the overrepresentation of Aboriginal and Torres Strait Islander children and young people within child protection systems and OOHC populations across Australia. In Queensland, Aboriginal and Torres Strait Islander children and young people are significantly over-represented in all aspects of child protection systems, including in OOHC. Despite accounting for only 9.4% of 0-17-year-olds, Aboriginal and Torres Strait Islander children and young people make up 47.2% of children and young people in OOHC and other supported placements.[xix] This means Aboriginal and Torres Strait Islander children are 8.6 times more likely than their non-First Nations peers to be in OOHC. Queensland has the highest reliance on residential care placement for Aboriginal and Torres Strait Islander children in Australia,[xx] making up 42% of all children living in residential care.[xxi] These patterns are relevant when considering any restrictive secure care model that draws its cohort from residential or other OOHC placements.

Children and young people positioned between service systems

Children and young people within the residential care population frequently present with acute behavioural distress, complex trauma histories, neurodevelopmental disability and significant mental health needs. Their level of risk, both to themselves and others, may exceed the capacity of standard residential care placements. At the same time, the complexity of these presentations often limits access to alternative care arrangements such as foster placements, and they often do not meet the statutory thresholds for involuntary admission under the *Mental Health Act 2016*.

A subset of this cohort also comes into contact with the criminal justice system. Children involved in the care and protection system are at an increased risk of anti-social, harmful or risky behaviour and possible interaction with the youth justice system, often at an earlier age than their peers[xxii]. Studies of dual-involved children have found nearly half have a neurodisability and have experienced more pronounced cumulative maltreatment and adversity than children and young people without dual involvement[xxiii].For some children with cognitive impairment or significant developmental disability, this pathway includes being charged with criminal offences but found unfit to plead or not criminally responsible. In practice, these children are often returned to residential care without a clear therapeutic or forensic pathway to address the underlying drivers of their behaviour, resulting in repeated cycles of police contact, emergency response and placement instability.

Over time, these dynamics can shift system responses toward managing perceived criminogenic risk rather than addressing underlying need. This may contribute to increasing pressure across service systems, including law

[xvii] **2024 Children in Care Census - Full Report for publication**
[xviii] Cheng, Z., Tani, M., Katz, I. (2025). Children with Disability in Out-of-Home Care: Prevalence and Characteristics. In: Bennett, G., Goodall, E. (eds) The Palgrave Encyclopedia of Disability. Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-031-40858-8_71-1
[xix] **Reviewing Implementation of the Aboriginal and Torres Strait Islander Child Placement Principle Queensland 2025 | Report | SNAICC**
[xx] Australian Productivity Commission, Report on Government Services 2022 – 16 Child protection services. Table 16A.22. Retrieved from: https://www.pc.gov.au/ongoing/report-on-government-services/2022/community-services/child-protection
[xxi] **Reviewing Implementation of the Aboriginal and Torres Strait Islander Child Placement Principle Queensland 2025 | Report | SNAICC**
[xxii] Baidawi, S., & Ball, R. (2023). Child protection and youth offending: Differences in youth criminal court-involved children by dual system involvement. Children and Youth Services Review, 144, 106736
[xxiii] Baidawi, S., & Piquero, A. R. (2021). Neurodisability among children at the nexus of the child welfare and youth justice system. Journal of Youth and Adolescence, 50(4), 803-819

enforcement and the broader community, and create conditions in which more restrictive interventions are viewed as necessary to contain risk. Experience in adult systems demonstrates that, in the absence of appropriate therapeutic pathways, similar trajectories have resulted in prolonged or indefinite forms of detention. This highlights the risk that secure care models may operate as a proxy response to system gaps, rather than as a clinically justified intervention.

In these circumstances, responsibility for responding to the child's needs may span child protection, disability, youth justice and health systems, with no single framework designed to address the full complexity of the presentation. Stabilisation pathways capable of providing sufficiently intensive clinical support can therefore be difficult to identify within existing legislative and service arrangements. This service interface is a recurring feature in secure care discussions across jurisdictions and is often a key driver of proposals for more restrictive environments.

Queensland's experience with restrictive environments

Queensland has direct experience that demonstrates that a secure care model can fail to achieve its therapeutic purpose even where detailed legislative frameworks and restrictive practice regulation exist.

Queensland operates a restrictive service model for adults with cognitive impairment through the Forensic Disability Service (FDS). The FDS is a medium secure 10-bed facility at Wacol, Brisbane. The FDS was established for the involuntary detention and care of people who have been found unfit to stand trial as a result of an intellectual or cognitive disability. Although established within a different statutory context, the experience of this model provides relevant insight into the practical challenges associated with highly restrictive and closed care environments and provides a relevant caution for proposals involving restrictive care environments for children and young people.

The legislative framework governing the FDS emphasises habilitation, rehabilitation and progression toward less restrictive environments. It also operates within a structured statutory regime regulating restrictive practices and decision-making oversight. Despite this governance architecture, independent oversight has identified significant challenges in achieving the model's intended purpose.

Reviews by the Queensland Ombudsman[xxiv] found that the FDS has failed to deliver programs to adequately promote the development, habilitation, rehabilitation and quality of life of people detained and that transition pathways to less restrictive environments have often been difficult to achieve in practice. In fact, after being in operation for more than five years, no person detained had been transitioned out of the facility even thought it was found that no detainees were continuing to benefit from the care and support provided by the service. The investigation found that this has impacted on their reintegration into the community, a key objective of the FD Act. Oversight findings have also identified instances in which restrictive practices were applied in ways that were "contrary to law, unreasonable, oppressive and improperly discriminatory"[xxv].

The investigation found a range of system-wide issues had contributed to administrative and operational failures of the FDS. These included that:

- the FDS has not embedded an appropriate and evidence-based approach to behaviour management
- there has been a lack of ongoing clinical expertise at the FDS

[xxiv] The Forensic Disability Service report - Queensland Ombudsman
[xxv] [xxv] The Forensic Disability Service report - Queensland Ombudsman, P8

- there has not been a consistent, comprehensive and structured approach to the delivery of healthcare services
- there has not been a consistent whole-of-service approach to working with Aboriginal and Torres Strait Islander peoples, families and communities
- despite the high proportion of people detained at the FDS who have a reported history of childhood trauma, approaches to trauma-informed care have not been appropriately considered, implemented or prioritised at the FDS.

The experience of the FDS demonstrates that the presence of legislative purpose, regulatory frameworks and oversight mechanisms does not in itself guarantee therapeutic outcomes or successful transition to less restrictive care. Where cohorts present with highly complex needs and alternative supports are limited, restrictive environments may become prolonged placements rather than short-term interventions.

Policy implications

Taken together, these features of the Queensland system illustrate the practical challenges associated with containment-style responses for children and young people with complex behavioural and clinical needs. They demonstrate a service environment already managing significant complexity, with responsibilities distributed across multiple service systems and incomplete regulatory safeguards governing restrictive responses affecting children and young people. In this context, the introduction of secure care would represent a significant escalation of restrictive intervention within a system that is grappling with the governance and therapeutic challenges of less restrictive models.

Interjurisdictional experience with secure care as a restrictive intervention

Secure care models operate in several Australian and comparable international jurisdictions. Evidence from these jurisdictions provides useful insight into how highly restrictive stabilisation environments function in practice, including the governance arrangements required to safeguard children and young people's rights when liberty-restricting interventions are used.

Across jurisdictions, models vary in their legal authorisation pathways, duration limits, clinical integration and oversight arrangements. Taken together, these systems also reveal recurring operational pressures associated with secure placements for children and young people with highly complex needs. These patterns provide relevant insight for the Commission's consideration.

Differences in interjurisdictional approaches are also shaped by whether restrictive interventions are considered within a statutory human rights framework. Jurisdictions such as Victoria, the ACT and Queensland operate under standalone human rights legislation which require public authorities to act compatibly with protected rights, including the right to liberty, protection of children and, in some jurisdictions, specific cultural rights for Aboriginal children. For example, in Victoria, decision-makers must consider whether any limitation on a child's rights is lawful, necessary and proportionate under the *Charter of Human Rights and Responsibilities Act 2006*[xxvi]. This creates an additional layer of scrutiny over decisions involving restriction of liberty. By contrast, jurisdictions without equivalent human rights legislation, such as New South Wales, South Australia and Western Australia, rely more heavily on administrative and policy-based safeguards. This contributes to variation in how consistently rights-based considerations are embedded in decision-making relating to restrictive interventions.

[xxvi] Charter of Human Rights and Responsibilities Act 2006 (Vic), s 7(2)

Cohort characteristics across jurisdictions

Across jurisdictions, secure care placements are typically drawn from residential care populations and involve children and young people with complex trauma, behavioural dysregulation and significant clinical needs.

For example, in Victoria, secure welfare services operate under the *Children, Youth and Families Act 2005* and provide placements for children and young people whose behaviour presents a serious and immediate risk of harm that cannot be managed without restricting their freedom of movement[xxvii] Reviews of the Victorian system have noted that the cohort often includes children and young people with complex trauma histories and significant behavioural needs, and that many have experienced multiple placement disruptions prior to admission.[xxviii]

Similarly, the Western Australian Kath French Secure Care Centre operates under the *Children and Community Services Act 2004* and provides short-term placements for children and young people assessed as presenting immediate risk to themselves or others. Reporting has identified that many children and young people admitted to the facility have experienced repeated placement breakdowns and have highly complex behavioural and clinical needs.[xxix]

Comparable patterns are also reflected internationally. In Scotland, secure accommodation is used for a small group of children and young people whose behaviour presents serious risk and who cannot safely remain in community placements.[xxx] Likewise, New Zealand care and protection residences are used for young people who cannot safely remain in community placements due to serious risk of harm.[xxxi]

In England, children and young people may be placed in secure accommodation under the *Children Act 1989* where statutory criteria are met.[xxxii] including circumstances in which a child is likely to abscond and suffer significant harm or where the child is likely to injure themselves or others. Children and young people placed in secure children's homes frequently present with complex trauma histories, behavioural dysregulation and significant mental health or neurodevelopmental needs, and many have experienced multiple placement disruptions prior to admission.[xxxiii]

Across jurisdictions, the effectiveness of secure care as a response to this cohort remains contested. While secure placements are typically introduced as short-term stabilisation interventions for children and young people presenting acute risk, research examining outcomes has found limited evidence that secure care improves longer-term wellbeing or behavioural outcomes for children and young people[xxxiv] Some analyses characterise secure care as providing a temporary "suspension of risk" rather than addressing the underlying drivers of a child's distress, including trauma, disability and unmet therapeutic need.[xxxv] Evidence also suggests that highly restrictive environments may be experienced by children and young people as punitive or retraumatising, particularly where they have already been exposed to abuse, instability or institutional care.[xxxvi]

[xxvii] *Children, Youth and Families Act 2005 (Vic)*, Part 6.1 (Secure welfare services)
[xxviii] Victorian Commission for Children and Young People, *Out of sight: systemic inquiry into secure welfare services in Victoria* (2016)
[xxix] *Office of the Auditor General for Western Australia, Placement Stability for Children in Care (2018); Telethon Kids Institute, Exploring Outcomes for Young People Who Have Experienced Out-of-Home Care (2019)*
[xxx] **PeakCare Discussion Paper March 2013**
[xxxi] S370 ***Children's and Young People's Well-being Act 1989***
[xxxii] https://www.legislation.gov.uk/ukpga/1989/41/section/25
[xxxiii] Children's Commissioner for England (2022), *Children in Secure Settings*
[xxxiv] Crowe, Kate. 2025. Secure Care in Australia—An Overview of Secure Care in Australian States and Territories and Commentary on the Legal Safety of Children Admitted to Secure Care in Australia. Social Sciences 14: 550.
[xxxv] Kate Crowe, *Secure Care for Children and Young People: International Approaches and Lessons for Australia* (Churchill Fellowship Report, 2023)
[xxxvi] Kate Crowe, *Secure Care for Children and Young People: International Approaches and Lessons for Australia* (Churchill Fellowship Report, 2023)

Secure care is framed as a short-term stabilisation intervention

Most secure care models are designed as short-term crisis stabilisation environments rather than long-term placements. Legislation and operational frameworks in several jurisdictions incorporate defined placement limits intended to reinforce this stabilisation purpose.

For example:

- In Western Australia, initial placements at the Kath French Secure Care Centre are limited to 21 days, with extensions permitted up to 42 days.[xxxvii]
- In Victoria, placements in secure welfare services are generally limited to 42 days, with mechanisms for extension.[xxxviii]
- In the ACT, the Intensive Therapy Order (ITO) framework allows confinement directions for a maximum of 14 days at a time, subject to cumulative limits and court oversight.[xxxix]
- In England, secure accommodation placements are authorised through time-limited Secure Accommodation Orders granted by the courts.[xl] Guidance also permits emergency placement in secure accommodation for short periods prior to court authorisation, typically not exceeding 72 hours in any 28-day period, after which judicial authorisation is required.[xli]

These limits reflect a consistent policy intention where secure care is designed to provide a temporary period of containment during which immediate risk can be managed and therapeutic assessment undertaken.

However, evidence from several jurisdictions indicates that maintaining this short-term stabilisation purpose can be difficult in practice. Reports from Western Australia[xlii] and Victoria[xliii] have identified cases of recurrent admissions, where children and young people cycle through secure placements multiple times over relatively short periods. In New Zealand, reviews of care and protection residences have identified significantly longer average stays in some facilities.[xliv] England has similarly identified pressures arising from limited secure children's home capacity, including instances in which children and young people are placed far from their home areas or where courts authorise alternative "deprivation of liberty" arrangements in non-secure residential settings when statutory secure accommodation placements are unavailable.

These observations suggest that, where step-down supports or alternative therapeutic placements are limited, secure environments become repeated or prolonged interventions rather than strictly time-limited stabilisation responses.

Legal authorisation and review

One of the most significant structural differences across jurisdictions concerns the legal basis on which a child's liberty may be restricted. In some systems, secure placements require independent judicial authorisation. For example, in New South Wales, placement in the Sherwood House secure care facility requires authorisation by the Supreme Court, with periodic review mechanisms.[xlv] Judicial authorisation provides visible proportionality safeguards by ensuring that the necessity and appropriateness of restricting a child's liberty are externally scrutinised.

[xxxvii] Children and Community Services Act 2004 (WA), secure care provisions (ss 88A–88J)
[xxxviii] **Placement in a secure welfare service - advice | Child Protection Manual | CP Manual Victoria**
[xxxix] Children and Young People Act 2008 (ACT), Intensive Therapy Order provisions inserted by the Justice (Age of Criminal Responsibility) Legislation Amendment Act 2023 (ACT).
[xl] **https://www.legislation.gov.uk/ukpga/1989/41/section/25**
[xli] **https://www.gov.uk/guidance/secure-childrens-homes-how-to-place-a-child-aged-under-13**
[xlii] Western Australian Parliament, *Evaluation of the Kath French Secure Care Centre* (2020)
[xliii] OPCAT in Victoria: A thematic investigation of practices related to solitary confinement of children and young people, September 2019
[xliv] **HardPlaceToBeHappy-FINAL.pdf**
[xlv] **WA.0011.0001.0010.pdf** pg 44

In Scotland, secure accommodation placements occur through the Children's Hearings system or court processes, both of which provide formal authorisation pathways and rights of appeal.[xlvi] In England, welfare-based secure accommodation placements are generally authorised by the courts, with time-limited orders and review requirements designed to ensure continued judicial scrutiny of the necessity and proportionality of detention.[xlvii] In some circumstances where the statutory framework does not apply, the High Court may authorise deprivation of liberty placements under its inherent jurisdiction.[xlviii]

Other jurisdictions rely more heavily on administrative decision-making under child protection legislation. In Victoria, secure welfare placements may occur through either court order or departmental authorisation under the *Children, Youth and Families Act 2005.*[xlix] Similarly, in Western Australia, placements at the Kath French Secure Care Centre follow assessment and panel review processes under the *Children and Community Services Act 2004.*[l] Internationally, authorisation frameworks also vary.

Interjurisdictional experience suggests that the strength and visibility of authorisation processes play a critical role in maintaining confidence that restrictive interventions are used only in exceptional circumstances. Where placements occur through administrative mechanisms, safeguarding protections depend more heavily on internal governance and oversight arrangements.

System capacity influences admission patterns

Interjurisdictional experience also demonstrates that admission patterns to secure care are influenced not only by individual risk, but by the broader capacity and configuration of the surrounding service system. Secure placements frequently occur following repeated placement breakdown or where existing residential or therapeutic services are unable to safely manage a child's behaviour. In these circumstances, secure care may function as an inappropriate response when other systems are unable to respond effectively.

Experience in England illustrates how system capacity pressures can shape decision-making in this area. Public reporting has identified ongoing shortages of secure children's home placements, resulting in children and young people being placed significant distances from their home areas or subject to alternative deprivation-of-liberty arrangements in non-secure residential settings when statutory secure accommodation placements are unavailable.[li] Concern has also been raised in relation to the use of secure care as a substitute for appropriate mental health treatment and support for children and young people in OOHC in Victoria.[lii]

Several jurisdictions have attempted to manage this dynamic by introducing additional decision-making structures designed to test whether secure placement is necessary.

In Australia, the ACT has adopted a structurally different approach through the establishment of the Therapeutic Support Panel under the Intensive Therapy Orders (ITO) framework. The Panel is a statutory multidisciplinary clinical body operating outside standard departmental decision-making structures and is responsible for coordinating therapeutic responses for children and young people whose needs cannot be met within existing services.[liii] The Panel holds decision-making authority in relation to therapeutic planning and is funded to

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[xlvi] **Secure Care - Children and Young People's Centre for Justice**
[xlvii] Cafcass (2023), *Guidance on Secure Accommodation Orders (s25 Children Act 1989)*
[xlviii] Cafcass (2023), *Guidance on Authorisation of Deprivation of Liberty under the Court's Inherent Jurisdiction*
[xlix] **Placement in a secure welfare service - advice | Child Protection Manual | CP Manual Victoria**
[l] Children and Community Services Act 2004 (WA), Part 4 Division 3 (Secure care)
[li] Nuffield Family Justice Observatory, *Children Deprived of Their Liberty in England* (2020)
[lii]
[liii] ACT Therapeutic Support Panel, *Annual Report 2024–25.*

coordinate or case manage cross-agency implementation. Importantly, the Panel's role is to identify and exhaust therapeutic and service responses before restrictive intervention is considered. Containment orders may ultimately be recommended through the ITO process, but only after alternative stabilisation pathways have been explored.

These approaches reflect recognition that the use of secure care is closely connected to the availability of alternative stabilisation and support pathways within the broader service system, and that decision-making structures may be required to test whether restrictive intervention is necessary.

Clinical governance and therapeutic integration

Evidence across jurisdictions indicates that outcomes are closely linked to the strength of clinical governance and the degree to which secure interventions are embedded within broader therapeutic systems. Models that demonstrate greater stability tend to integrate multidisciplinary clinical leadership, structured therapeutic planning and coordination across service systems.

The ACT's Therapeutic Support Panel framework provides a leading example of this approach and provides a useful benchmark for system design. The Therapeutic Support Panel brings together senior representatives from child protection, health and disability, and operates with clear authority to direct therapeutic planning across systems.

Importantly, the ACT model is not built around a standalone secure facility. It is funded and structured as a clinical case management and decision-making model, with restrictive interventions positioned as a last resort within a broader therapeutic continuum. The Panel is responsible for actively exploring alternative stabilisation pathways (including intensive community-based supports and coordinated service responses) prior to any consideration of containment[liv]. Where containment is authorised through the Children's Court, it occurs within a time-limited, clinically governed therapeutic plan, rather than as an institutional placement.

Outcomes reported by the ACT indicate that this model enables both client-level stabilisation and system-level change[lv]. Engagement rates of approximately 93% have been achieved with a highly complex cohort, reflecting the effectiveness of a therapeutic alliance as the entry point for intervention. Early outcomes include improved safety and stability, reduced absconding and harmful behaviours, and strengthened relationships with carers and supports. These changes are often achieved through coordinated adjustments to living arrangements, targeted therapeutic interventions, and sustained cross-agency involvement. At a system level, the model has strengthened referral pathways (including increased referrals from policing), improved access to therapeutic services, and driven greater consistency in trauma-informed practice across care teams.

Reform work in Scotland, including the Reimagining Secure Care program[lvi] undertaken following the Independent Care Review, has similarly emphasised strengthening therapeutic models and diversion pathways designed to reduce reliance on secure accommodation.

England's secure children's homes are likewise intended to operate as welfare-based environments combining care, education and therapeutic support for highly vulnerable children and young people.[lvii] Inspection frameworks applied by the Office for Standards in Education, Children's Services and Skills[lviii] place significant

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[liv] *Children and Young People Act 2008 (ACT)*, Intensive Therapy Order provisions inserted by the Justice (Age of Criminal Responsibility) Legislation Amendment Act 2023 (ACT)

[lv] **https://www.act.gov.au/__data/assets/pdf_file/0011/2975438/Therapeutic-Support-Panel-Report-2025.pdf**, pp.22-24

[lvi] **Reimagining-Secure-Care-Final-Report.pdf**

[lvii] https://www.gov.uk/government/publications/secure-childrens-homes-how-places-are-managed-and-allocated

[lviii] **Ofsted, *Social Care Common Inspection Framework (SCCIF): Secure Children's Homes***

emphasis on the impact of care on children and young people's experiences and progress, reflecting an expectation that secure placements deliver measurable therapeutic and developmental outcomes rather than functioning solely as containment settings.

By contrast, oversight and review processes in several jurisdictions operating facility-based secure care models have raised concerns regarding therapeutic sufficiency, workforce capability and repeat admissions. For example, reviews of secure welfare services in Victoria,[lix] Western Australia[lx] and New Zealand[lxi] have identified challenges in maintaining a clear therapeutic model and ensuring effective transition pathways. Where clinical governance is weakly integrated with broader health and disability systems, containment may become the dominant operational response to behavioural distress rather than a component of a coordinated therapeutic intervention.[lxii]

Restrictive practices transparency

Inspection and oversight processes across jurisdictions consistently identify the management of restrictive practices as a central safeguarding issue in secure environments. Closed settings create conditions in which practices such as restraint, seclusion or environmental confinement may arise. As a result, oversight bodies frequently focus on the transparency, authorisation and monitoring of such practices.

For example:

- Inspection findings in Victoria[lxiii] have raised concerns regarding the use of isolation practices.
- Reviews in New Zealand[lxiv] have documented the continued use of seclusion and restraint in care and protection residences, alongside concerns regarding workforce capability and safety.
- Oversight material from Western Australia[lxv] has emphasised the importance of clinical governance and transparency in the management of restrictive interventions. Concerns have also been raised about a lack of independent oversight of the centre's operations.[lxvi]

Disproportionate representation and cultural considerations

Because secure care cohorts are typically drawn from residential care placements, patterns of overrepresentation within child protection systems can also be reflected within restrictive care settings. Several jurisdictions have identified disproportionate representation of First Nations children and young people within secure care placements.

In addition to issues of representation, the operation of secure facilities may also create risks of geographic and cultural disconnection. Reporting in Western Australia has highlighted the impact of geographic distance and cultural disconnection where Aboriginal children and young people are placed in secure facilities located away from their families and communities.[lxvii] These dynamics raise particular safeguarding considerations in restrictive environments, where opportunities to maintain connection to culture, community and Country may be further

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[lix] Victorian Commission for Children and Young People, *Out of sight: systemic inquiry into secure welfare services in Victoria* (2016); **https://www.legalaid.vic.gov.au/solitary-confinement-harming-children-our-submission-victorian-ombudsman**.
[lx] Western Australian Ombudsman, *Investigation into Secure Care Arrangements for Children and Young People* (2014); **Inquest into the Death of CHILD RM**
[lxi] Office of the Ombudsman (New Zealand), *Oranga Tamariki – Investigation into the secure residences and the use of seclusion* (2021); Independent Children's Monitor, *Experiences of Care in Oranga Tamariki Residences* (2023)
[lxii] Crowe, S., *Secure Care Models for Young People at Risk of Harm* (Report to the South Australian Child Protection Systems Royal Commission, 2016).
[lxiii] OPCAT in Victoria: A thematic investigation of practices related to solitary confinement of children and young people, September 2019
[lxiv] **Care and protection, or containment and punishment? How state care fails NZ's most vulnerable young people | RNZ News**; Oranga Tamariki Rapid Review, September 2023
[lxv] Western Australian Ombudsman, *Investigation into Secure Care Arrangements for Children and Young People* (2014)
[lxvi] **Young kids locked up in secure care | The West Australian**
[lxvii] Crowe, K. (2025). Secure Care in Australia—An Overview of Secure Care in Australian States and Territories and Commentary on the Legal Safety of Children Admitted to Secure Care in Australia. Social Sciences, 14 (9)

constrained. These patterns underscore the importance of culturally informed governance and oversight where restrictive interventions affect children and young people from communities already overrepresented in child protection systems.

Implications for policy design

The experiences of these jurisdictions demonstrate that the operation and impact of secure care models are shaped less by the existence of a facility itself than by the broader governance, service system capacity and safeguards surrounding its use.

Jurisdictions that have implemented secure care have consistently encountered similar structural pressures, including a small cohort with highly complex needs, limited stabilisation pathways outside restrictive environments, and ongoing challenges in maintaining the intervention as a short-term therapeutic response rather than a recurrent placement pathway.

Collectively, these observations suggest that the central policy question is not whether more restrictive environments are required, but how decision-making for this cohort is structured across systems. Interjurisdictional experience demonstrates that multidisciplinary clinical decision-making approaches can provide a more effective mechanism for coordinating stabilisation responses without reliance on facility-based containment. The ACT model provides a particularly instructive example of how such an approach can be operationalised in practice.

RECOMMENDATION: OPG recommends that Queensland not establish a facility-based secure care model. Instead, a multidisciplinary, clinical decision-making model should be adopted (such as the ACT Therapeutic Support Panel framework), which:

- coordinates cross-agency clinical and therapeutic responses
- embeds decision-making authority across child protection, health and disability systems
- requires that less restrictive alternatives are actively explored and exhausted
- enables time-limited containment interventions only where necessary
- operates under independent authorisation and judicial oversight
- provides a structured mechanism for responding to acute risk without reliance on institutional secure care environments

Minimum safeguarding architecture for a secure care model in Queensland

If, notwithstanding the risks identified and evidence of models that rely on clinical case management and decision-making rather than facility-based containment, the Commission were to consider recommending a secure care pathway in exceptional circumstances, international human rights frameworks and interjurisdictional experience indicate that the following structural safeguards would be necessary.

Independent judicial authorisation and review

Interjurisdictional models vary in this respect; some rely on administrative authorisation under child protection powers, while others require court orders. It is important to distinguish between the authorisation of restrictive practices used within care settings and decisions that involve the deprivation of a child's liberty through containment in a closed environment. While restrictive practices (including some environmental restrictions) should be subject to independent authorisation through a specialist statutory function such as a Senior Practitioner, more intensive interventions that confine a child and prevent them from leaving a placement should be treated as a deprivation of liberty requiring judicial oversight.

OPG submits that judicial authorisation by the Supreme Court would provide an appropriate level of independent scrutiny given the gravity of restricting a child's liberty outside the criminal justice system. Judicial authorisation would ensure that the statutory threshold for such an intervention is externally tested and that the necessity and proportionality of the placement are subject to independent review. This approach ensures that secure care is not authorised in the same way as other restrictive practices but is instead recognised as a distinct category of intervention requiring a higher safeguard threshold.

Regular review mechanisms would also support alignment between the placement and its stated crisis-stabilisation purpose, ensuring that any deprivation of liberty remains time-limited, justified and subject to ongoing independent scrutiny.

RECOMMENDATION: OPG recommends that any intervention involving the confinement of a child or young person in a closed environment be subject to independent judicial authorisation and review. This should:

- recognise deprivation of liberty as a distinct and highly restrictive intervention
- ensure necessity and proportionality are independently tested
- include time limits and regular review mechanisms

Short-duration stabilisation model

Secure care interventions are most coherent when they operate as short-term stabilisation mechanisms rather than substitute responses to broader service system pressures. Clear maximum placement periods, coupled with structured scrutiny of extensions, therefore function as both child safeguards and systemic constraints on the expansion of use. In this respect, the model adopted in the ACT provides an example of an approach where the restrictive intervention can be embedded within a funded multidisciplinary clinical case management and decision-making framework, rather operating as a standalone closed placement. This approach reflects legislative intent in the ACT to prioritise multidisciplinary, therapeutic decision-making and the least restrictive response when considering interventions that may limit a child's liberty[lxviii].

Models of this kind are more likely to support appropriate and proportionate decision-making because they embed multidisciplinary clinical expertise at the point of decision, rather than relying solely on administrative or program-based decision-making within individual agencies. In practice, decision-making that sits across government agencies operating within separate legislative mandates and funding constraints can be influenced by system limitations as well as the child's needs. By contrast, multidisciplinary panels with dedicated clinical input are better positioned to assess risk in context, identify less restrictive alternatives and ensure that any stabilisation intervention is aligned with a therapeutic pathway rather than functioning as a default containment response.

Clinical governance and mental health integration

Clear clinical governance is an essential safeguard. This requires defined clinical leadership, multidisciplinary treatment planning and integration with external health and disability services to ensure that any stabilisation intervention remains connected to ongoing therapeutic care rather than functioning as a stand-alone containment placement.

[lxviii] CHILDREN AND YOUNG PEOPLE BILL 2008 Explanatory Statement

Independent oversight and advocacy

OPG's community visitors provide independent monitoring in visitable environments and assist individual children and young people to raise concerns about their treatment and care. However, while these functions provide an important safeguard at the level of individual engagement, there is currently no mechanism specifically focused on advocating for the rights and interests of children and young people with cognitive impairment who are subject to liberty-restricting interventions. For this cohort, reliance on individual complaint or advocacy pathways alone would not be sufficient to identify or address systemic risks associated with restrictive care environments.

In adult service systems, specialised systemic advocacy performs an important function for individuals with impaired capacity who are subject to restrictive interventions. Queensland's Public Advocate performs functions of this kind and the Commission may wish to consider whether comparable safeguards may be required where restrictive care arrangements affect children and young people with cognitive impairment.

RECOMMENDATION: OPG recommends that an independent statutory function be established or expanded (such as the Public Advocate or equivalent) to provide specialised systemic advocacy and oversight for children and young people with cognitive impairment.
This function should provide:

- independent, system-level advocacy
- specialist expertise in impaired capacity
- oversight of how restrictive practices are applied to this cohort across systems

Restrictive practices regulation

Consideration would need to be given to whether the authorisation, reporting and oversight of restrictive practices in any secure care environment should be clearly defined in legislation and aligned, where appropriate, with the safeguards that apply in comparable adult service systems.

Cultural governance and First Nations engagement

Development of any secure intervention pathway must be informed by meaningful engagement with Aboriginal and Torres Strait Islander organisations and communities, including consideration of co-design approaches in policy development, oversight arrangements and service delivery frameworks. Embedding cultural governance within the architecture of the model may assist in ensuring that responses affecting Aboriginal and Torres Strait Islander children and young people are informed by community knowledge and culturally appropriate practice.

Data transparency and evaluation

Interjurisdictional experience indicates that routine reporting on admissions, duration of stay, repeat placements, use of restrictive practices, demographic characteristics and post-discharge outcomes assists in identifying emerging risks and assessing whether the model is operating within its intended parameters. Establishing a defined minimum dataset, accompanied by regular public reporting and mandatory independent evaluation within a fixed timeframe, would support objective assessment of effectiveness, proportionality and equity impacts over time.

Conclusion

Queensland does not currently have a comprehensive legislative framework governing restrictive practices affecting children and young people in out-of-home care. This creates a significant safeguarding gap in a system where highly restrictive interventions may already be occurring, including practices that restrict liberty, isolate

children from carers or rely on behaviour-modifying medication, without equivalent independent authorisation, transparency or oversight.

Secure care would represent the most restrictive end of this continuum. It would authorise the confinement of a child within a closed environment and should not be approached as a standalone placement response or operational extension of residential care. Interjurisdictional evidence indicates that secure care models commonly emerge in response to a small cohort of children and young people with highly complex needs who sit across child protection, disability, mental health and, at times, youth justice systems. While these models are typically framed as short-term stabilisation interventions, experience across jurisdictions demonstrates that restrictive environments can become prolonged, repeated or embedded responses where therapeutic pathways, clinical governance and step-down supports are limited.

For these reasons, OPG does not support the establishment of a facility-based secure care model in Queensland. If the Commission considers that a mechanism is required to respond to a small cohort of children and young people with acute and complex needs, OPG's position is that Queensland should look instead to a multidisciplinary clinical decision-making model of the kind reflected in the ACT Therapeutic Support Panel framework. That model demonstrates how cross-agency clinical governance, structured therapeutic planning and court-supervised, time-limited containment can be combined without creating a standing institutional secure care environment. It offers a more proportionate and rights-protective response to acute risk, while maintaining focus on therapeutic stabilisation.

More broadly, the issues examined in this submission point to the need for system reform that extends beyond the question of secure care itself. Restrictive practices affecting children and young people should be governed through a clear, cross-sector legislative framework that applies across child protection, disability and health systems, distinguishes between restrictive practices and deprivation of liberty, and provides consistent safeguards, monitoring, reporting and accountability. This should be supported by independent clinical authorisation, stronger data transparency, workforce capability uplift, and appropriate systemic advocacy for children and young people with cognitive impairment or decision-making vulnerability.

The Commission is therefore urged to consider not only whether a secure care model should be introduced, but whether Queensland's broader legal and service system architecture is capable of governing restrictive interventions affecting children in a way that is lawful, proportionate, transparent and rights-protective. OPG's position is that it is not, and that reform should be directed toward building that architecture rather than institutionalising a more restrictive model in its absence.

public guardian
Queensland