The Department of Communities and Justice
Locked Bag 5000
Parramatta NSW 2124

By e-mail: policy@dcj.nsw.gov.au

28 February 2025

RE: A LEGISLATIVE FRAMEWORK TO REGULATE RESTRICTIVE PRACTICES

The Intellectual Disability Rights Service Inc (**IDRS**) welcomes the opportunity to respond to *A Legislative Framework to Regulate Restrictive Practices* ('Consultation Paper').

About the Intellectual Disability Rights Service

IDRS provides legal and disability advocacy services for people throughout NSW living with cognitive impairment. IDRS is the only service of its kind in Australia and offers two main service functions. Firstly, the IDRS Ability Rights Centre (ARC), offers free legal assistance to people living with a disability across NSW, prioritising those with intellectual disability. ARC supports on average 850 people per year. In addition to legal advice and representation, ARC services include support for parents with intellectual disability involved in care and protection matters, education and group programs for people with cognitive disability and support for people appealing to the Administrative Review Tribunal for review of decisions made by the National Disability Insurance Agency.

Secondly, the IDRS Justice Advocacy Service (JAS) provides 24/7 support across NSW to people with cognitive impairment in criminal proceedings. Each year, JAS supports on average 2,500 people with cognitive impairment, including approximately 2,250 people recorded as offenders and 200 people recorded as victims of crime. We successfully advocate for over 300 people per annum to receive diversion in place of a custodial sentence.

Introduction

Bodily autonomy is a human right.[1] It therefore bears stressing that any practice seeking to restrict this right is harmful. For the purposes of this submission, a restrictive practice is defined as 'any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability'.[2] This includes seclusion, physical restraint, chemical restraint, mechanical restraint or environmental restraint used across disability service provision, health, education and justice settings.[3]

The need to reduce and eliminate restrictive practices has been amply documented. In its Final Report, The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability

[1] See *Universal Declaration of Human Rights*, GA Res 217 A (III), UN GAOR, UN Doc A/810 (10 December 1948); *United Nations Convention on the Rights of Persons with Disabilities*, GA Res 61/611, UN GAOR, UN Doc A/RES/61/106 (13 December 2006).
[2] *National Disability Insurance Scheme Act 2013* (Cth) s 9 (definition of 'restrictive practice').
[3] *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Final Report, September 2023) vol 6, 432 *('Disability Royal Commission')*.

ABN 11 216 371 524
PO Box 20228, World Square NSW 2002
• P 1300 665 908 • P 02 9265 6300 • F 02 9265 6333
www.idrs.org.au

Royal Commission) recommended strengthening legal frameworks to reduce and eliminate restrictive practices.[4] The Disability Royal Commission's research report, 'Restrictive practices: A pathway to elimination', further described these practices as being 'at odds with the human rights of people with disability' and representing 'a significant form of violence and coercion.'[5] It went on to propose an 8-point plan to eliminate restrictive practices, which included, for example: 'an immediate legal prohibition of the use of restrictive practices on a discriminatory basis against people with disability'; '[investment] in strategies to change the socio-cultural attitudes and norms driving restrictive practices'; and '[protecting] the autonomy of people with disability to make decisions about what happens to their bodies and lives'.[6]

As we work toward eliminating restrictive practices, IDRS strongly believes that we must at all times promote a human rights-based approach that privileges the rights and consent of people with disability, the people upon whom restrictive practices are applied, to the fullest extent possible. At the same time, we must ensure that if a restrictive practice is applied, it is in fact the last resort and subject to rigorous scrutiny, robust safeguards, and effective governance structures.

Of course, this is not always the case. In Australia, unauthorised restrictive practices remain sufficiently widespread to merit serious concern. For the 12 months to June 2022, for example, the National Disability Insurance Scheme (NDIS) providers notified the NDIS Commission of 1,422,295 unauthorised uses of restrictive practices (URPs) relating to 8,830 NDIS participants.[7]

IDRS has previously made submissions expressing concerns about the unfettered and unregulated use of restrictive practices, including to the Disability Royal Commission, the NSW Law Reform Commission, and the National Disability Insurance Scheme Review. In principle, we support any reform that will help to reduce and eliminate the use of restrictive practices.

However, our broad position is that the evidence base set out in the Consultation Paper does not sufficiently justify or articulate why the proposed legislative framework is fit for purpose and how it will help to deliver a reduction in the use of restrictive practices. Our concerns are twofold. First, in our view the elimination of restrictive practices is unlikely to be addressed by a legislative framework alone. It will also require transformational and culture change across disability service provision, health, education and justice settings.

Second, IDRS is concerned that focusing on NDIS participants is unlikely to significantly reduce restrictive practice use. We respectfully submit that any legislative regime should be broader in scope and have population-wide effect. IDRS clients, for instance, often report being subjected to a range of restrictive practices such as seclusion (including 'dry cells'), physical, mechanical, and environmental restraints. Yet in 2024, for example, only around a quarter of IDRS JAS clients in contact with the criminal justice system were NDIS participants. At the NSW level, we understand that there were 4,371 NDIS participants

[4] *Disability Royal Commission* (n 3) 430.
[5] The University of Melbourne, University of Technology Sydney and the University of Sydney, 'Restrictive practices: A pathway to elimination' (Research Report, The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, July 2023) 1.
[6] Ibid 12-13.
[7] NDIS Quality and Safeguards Commission, *The Unauthorised Uses of Restrictive Practices in the National Disability Insurance Scheme report* (February 2023) 6.

ABN 11 216 371 524
PO Box 20228, World Square NSW 2002
• P 1300 665 908 • P 02 9265 6300 • F 02 9265 6333
www.idrs.org.au

associated with regulated restrictive practice notifications for the period July to September 2023, constituting 2.3 per cent of the total NDIS participant population; and 1,726 unauthorised restrictive practice notifications for the same period.[8] Again, it is our view that the focus of the legislative regime must be broader than NDIS participants if it is to achieve its objective.

Our strong preference is to set aside the proposed legislative framework put forward in the Consultation Paper. If it is retained, however, we believe the existing cultural, regulatory and operational landscape must first be identified, mapped and analysed. To that end, this submission will respond to the consultation questions focusing on issues ranging from consent and culture to resourcing, education and training.

Responses to Consultation Questions

Question 1: Should the proposed legislative framework cover the out of home care setting?

Yes. IDRS notes that children with disability are overrepresented in out-of-home care[9] and especially vulnerable to abuse, neglect and maltreatment.[10] As such, we believe that the proposed legislative framework should cover out of home care settings, including any NDIS-funded residential provider settings.

Of IDRS's ARC clients accessing family law and family violence support services for the period July 2024 to December 2024, 24% were Indigenous Australians. 4% were under the age of 17. Separately, IDRS's ARC *Parent Project* service assists people with cognitive impairment who have either had their children removed or who are at risk of having their children removed. From July 2023 to June 2024, the *Parent Project* supported 136 individual clients. Of these, 36 clients identified as Aboriginal and/or Torres Strait Islander.

Question 2: Should the proposed legislative framework cover any other setting?

IDRS supports a legislated definition of restrictive practice that applies to NDIS-funded residential provider settings. Most IDRS clients are people with disability who reside in five residential environments, including:

- out of home care;
- at home with carers or partners;
- NDIS-funded residential provider settings (specialist disability accommodation);
- independent living with paid NDIS supports;
- aged care (including young people with disability who are placed in aged care).

The definition should therefore apply to all these settings.

[8] NDIS Quality and Safeguards Commission, *Quarterly Performance Report: Q1 2023-24* (Report, 2024) 34, 37 <www.ndiscommission.gov.au/sites/default/files/2024-09/quarterly-report-july-september-2023.pdf>.
[9] Zhiming Cheng, Massimiliano Tani and Ilan Katz, 'Outcomes for children with disability in out-of-home care: Evidence from the pathways of care longitudinal study in Australia' (2023) 143 *Child Abuse & Neglect* 1.
[10] Kathomi Gatwiri, Lynne McPherson and Samara James, 'Experiences of Children and Young People with a Disability in Out-of-Home Care in Australia: A Scoping Review' (2024) *Health & Social Care in the Community* 2.

ABN 11 216 371 524
PO Box 20228, World Square NSW 2002
• P 1300 665 908 • P 02 9265 6300 • F 02 9265 6333
www.idrs.org.au

Question 3: What issues and challenges are raised by there being different frameworks for the authorisation of restrictive practices in the disability service provision setting and the aged care setting?

IDRS believes there is likely to be a range of issues and challenges related to the authorisation of the use of restrictive practices. Chief among them is the risk of regulatory duplication and conflict. IDRS understands that in 2021 the *Aged Care Act 1997* and the *Quality of Care Principles 2014* were amended with changes to the definition of restrictive practice, requirements for residential aged care providers, the introduction of compliance notices and civil penalties for providers who breach restrictive practice responsibilities.[11]

IDRS considers that, in most cases, the proposed framework will not apply to people in aged care settings unless they are receiving NDIS services. That said, there may be potential duplication with the proposed legislative framework and other bodies such as, for example:

- The NDIS Quality and Safeguards Commission
- The Aged Care Quality and Safety Commission
- The NSW Ageing and Disability Commission
- The Official Community Visitor Scheme
- The NSW Guardianship Tribunal

Further to the last point, it is unclear as to whether and in what circumstances the proposed Senior Practitioner model might interact with the *Guardianship Act 1987* (NSW), and whether the Senior Practitioner role bypasses the role of the Guardianship Tribunal.

Second, there may be operational and compliance challenges for providers attempting to apply the various frameworks, including confusion around roles and responsibilities, and obligations and reporting requirements. For instance, one contributor quoted in the statutory review of the ACT's *Senior Practitioner Act 2018* (ACT Review), indicated that aged care providers may simply be unaware as to who is a NDIS participant:

> They may not know where the funding comes from and have refused access to [the] Senior Practitioner. One provider had 4 people who were subject to restrictive practices; they said the Senior Practitioner can't come in. There were letters from [the] NDIS Quality and Safeguards Commission and [the] Senior Practitioner. They tried a joint visit. In breach of the Aged Care Act, they exited the 4 people. Reports were made to the Aged Care Commission.[12]

Third, there may be confusion caused for NDIS participants seeking to exercise their rights, including confusion around which process to use to lodge complaints or how to seek review of decisions.

[11] Aged Care Quality and Safety Commission, *Restrictive Practices: Key changes for providers from 1 July 2021 – fact sheet* (13 July 2021). <www.agedcarequality.gov.au/sites/default/files/media/fact-sheet-restrictive-practices-key-changes-for-providers-1-july-2021.pdf>.
[12] ACT Government and Purple Orange, *Statutory review of the Senior Practitioner Act 2018 (ACT): Final Report* (April 2024) 34 (*'ACT Review'*).

ABN 11 216 371 524
PO Box 20228, World Square NSW 2002
• P 1300 665 908 • P 02 9265 6300 • F 02 9265 6333
www.idrs.org.au

Question 4: Do you support legislation requiring that restrictive practices on NDIS participants in the disability service provision, health, education and justice settings should be governed by the principles recommended by DRC Recommendation 6.35(b)?

Yes.

Question 5: Are there any other principles that should be considered

Overall, we believe the number of principles set out in DRC Recommendation 6.35(b) are sufficient. However, given the term 'supported decision-making' is often understood differently across different disciplines, professions and sectors, we believe it should be defined and described in more detail.[13]

Question 6: Should a legislative framework prohibit any practices? If so, which practices and in which settings?

IDRS would support a proposed legislative framework that prohibits certain practices, including those set out in Appendix B of the Consultation Paper. However, if it can be shown that there was a need for the practice to be used as a last resort to ensure the safety of the NDIS participant, then the Senior Practitioner should be empowered to authorise the restrictive practice. Authorisations should be open to internal review and be reviewable by NCAT (see Question 15).

Question 7: Do you agree that:

- **the framework should use the NDIS definitions of restrictive practices?**
- **the Senior Practitioner should have the power to issue guidelines that clarify how the definitions apply in different situations?**

Broadly, IDRS agrees with the NDIS definitions in section 9 of the *National Disability Insurance Scheme Act 2013* (Cth) (NDIS Act) and section 6 of the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth) (NDIS Rules). However, we are also of the view that the definitions are not detailed enough and must clearly articulate what constitutes a restrictive practice. IDRS solicitors often give advice on issues relating to the definition of a restrictive practice. We also regularly advise workers and carers on whether to obtain guardianship orders in a variety of circumstances including, for example, closing doors to prevent a person with disability escaping onto the road and being injured; or locking kitchen cupboards to a person with Prader-Willi syndrome.

As to the second limb of the question, IDRS believes that the Senior Practitioner should have the power to issue guidelines clarifying how the definitions apply in different situations.

[13] La Trobe University, 'Diversity, dignity, equity and best practice: a framework for supported decision-making' (Research Report, The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, January 2023) 19-24.

ABN 11 216 371 524
PO Box 20228, World Square NSW 2002
• P 1300 665 908 • P 02 9265 6300 • F 02 9265 6333
www.idrs.org.au

Question 8: What role should the Senior Practitioner play in regulating behaviour support plans? For example:

- **Should the Senior Practitioner have the power to prescribe additional and/or more detailed information for inclusion in the BSP? If so, what information?**
- **Should the Senior Practitioner have the power to require a behaviour support practitioner have certain qualifications and the Senior Practitioner's approval before they can prepare a BSP which will be used to authorise the use of a restrictive practice? If so, what should the additional qualifications and criteria for approval be?**
- **Should there be any specific provisions relating to consultation in the development of a BSP, in addition to the requirements in the NDIS Rules?**

First, we believe the Senior Practitioner should have the power to prescribe additional and/or more detailed information for inclusion in the Behaviour Support Plan (BSP) to help improve their quality. The kind of information prescribed might include, for example, what worked or did not work previously.

Second, IDRS considers that the Senior Practitioner should have the power to require a behaviour support practitioner have specialist qualifications - or equivalent experience - and the Senior Practitioner's approval before they can prepare a BSP that will be used to authorise the use of a restrictive practice. Mandatory qualifications and/or training should be in the area of behaviour management.

Third, in IDRS's view, whoever is developing the BSP should be required to meet and consult with the client, and/or the client's primary carer or support worker to help ensure that implementation occurs as expressed in the plan. The plan should be reviewable and decisions appealable.

Question 9: Is there anything else the proposed framework should do to improve the quality of BSPs?

Contributors to the ACT Review observed that 'the quality of positive behaviour support plans improved following the wider usage of the Behaviour Support Plan Quality Evaluation Tool (BSP-QEII)'.[14] However, the ACT Review also found that the improvement in the quality of positive BSPs was hindered by a range of factors, including the shortage of suitably qualified behaviour support practitioners.[15]

As the effective implementation of a BSP rests largely on a skilled and well-resourced workforce, whichever model is adopted must consider the capacity of the NDIS system and the providers to implement. At present, it is our opinion that NDIS funding structures are not adequately resourced to enable the retention of highly skilled staff and facilitate sustained training and support.

[14] *ACT Review* (n 12) 16.
[15] *ACT Review* (n 12) 44.

ABN 11 216 371 524
PO Box 20228, World Square NSW 2002
• P 1300 665 908 • P 02 9265 6300 • F 02 9265 6333
www.idrs.org.au

Question 10: Should APOs be empowered to either:

- **authorise particular categories of restrictive practices without separate Senior Practitioner authorisation (a partially delegated model). If so, what categories of restrictive practices should be able to be authorised by APOs? Should these be prescribed by legislation, or through class or kind orders?**
- **provide preliminary approval of restrictive practices, with final authorisation provided in all cases by the Senior Practitioner (a two step model)?**
- **What would be the benefits and risks of the above models?**

IDRS believes that in the first instance and where possible, consent should be obtained from the person with disability or their alternate decision-maker where the person has one.

If the proposed Senior Practitioner model is introduced, our preference is the two-step model where an Authorised Program Officer (APO) or a Panel approves the use of the restrictive practice and final authorisation is required from the Senior Practitioner. While we acknowledge the two-step model may create a bottleneck for the Senior Practitioner, we believe the increased visibility will enable the Senior Practitioner to better respond to, and ultimately ameliorate, potential abuse.

Question 11: Are there alternative approaches to authorisation that would be preferable to these models?

An alternative approach to authorisation might involve the service provider reporting on how they obtained the NDIS participant's consent or, where the participant is unable to consent, the steps taken to obtain consent from their carer, partner or guardian or their alternative decision maker.

Question 12: Should APOs be required to be employed by a single provider? Or should APOs be permitted to be consultants to a number of providers? If so, what safeguards should there be in relation to this?

IDRS acknowledges the potential challenges associated with resourcing and implementing a model where an APO is employed by a single provider, particularly for small providers. However, permitting APOs to be consultants to a number of providers – in addition to their responsibilities to the Senior Practitioner – may create the potential for conflict of interest. If permitting APOs to consult to multiple providers is the only feasible resourcing model, the associated risk may be mitigated through the establishment of a professional accreditation process or similar overseen by the Senior Practitioner (see Question 26). An accreditation process would need to be accompanied by strong governance principles, including transparency, reporting, complaints and review mechanisms.

Question 13: Do you support the proposed duration of authorisation and emergency use proposals for restrictive practices?

IDRS supports the proposed 12 months duration of authorisation and emergency use proposals for restrictive practices, but we consider that it must come with review mechanisms. We also note that it can take many months for a BSP to be developed and during this time the NDIS participant's circumstances may change considerably.

ABN 11 216 371 524
PO Box 20228, World Square NSW 2002
• P 1300 665 908 • P 02 9265 6300 • F 02 9265 6333
www.idrs.org.au

Question 14: Are there any additional grounds on which the Senior Practitioner should be able to cancel an authorisation?

Yes. The Senior Practitioner should be able to cancel an authorisation on the application of the NDIS participant. The Senior Practitioner should also be able to cancel an authorisation of a service provider where there have been findings of misconduct, abuse or criminal behaviour.

Question 15: Should authorisation decisions:

- **be open to internal review?**
- **be reviewable at NCAT?**

We are of the view that authorisation decisions should be open to internal review and be reviewable at NCAT.

Question 16: Should rights to seek review be limited to the person or a person concerned for their welfare? Should the service provider have a right to seek review of a decision not to authorise a restrictive practice?

We believe the person or another person concerned with the NDIS participant's welfare should be able to seek review. The service provider should *not* have a right to seek review of a decision not to authorise a restrictive practice. Service providers should instead amend their proposal to a restrictive practice such that there is no breach. In instances where a service provider has had more than one application overturned, the Senior Practitioner could conduct a review of the service provider's decision-making framework.

Question 17: Should a person have a right to request the service provider review the BSP at any time?

Yes.

Question 18: Should the Senior Practitioner have complaints handling and investigation functions either on receipt of a complaint, on its own motion, or both?

Our view is that the Senior Practitioner should have complaints handling and investigation functions both on receipt of a complaint and on its own motion. The latter is critical given some NDIS participants may not have carers or advocates.

Question 19: Do you agree the Senior Practitioner should have the proposed powers to respond to misuse of a restrictive practice?

We agree that the Senior Practitioner should have the proposed powers to respond to misuse of a restrictive practice. This should include:

- a power to order that the restrictive practice cease immediately;
- a power to investigate whether the restrictive practice has ceased;
- an obligation to report criminal offences to police for further investigation;

ABN 11 216 371 524
PO Box 20228, World Square NSW 2002
• P 1300 665 908 • P 02 9265 6300 • F 02 9265 6333
www.idrs.org.au

- an obligation to notify the NDIS participant or their carer of their right to obtain legal advice with respect to civil action.

Question 20: How should interaction with the NDIS complaints framework be managed?

IDRS suggests that all interactions be identified and mapped, including roles and responsibilities, policies, processes, reviews and reporting pathways to reduce the risk of duplication and inconsistency across the various frameworks. The potential scope of interactions may encompass, for example:

- The Guardianship Tribunal of New South Wales
- The Aged Care Quality and Safety Commission
- The NDIS Quality and Safeguards Commission
- The New South Wales Ombudsman
- The Office of the Children's Guardian
- The Inspector of Custodial Services
- The Law Enforcement Conduct Commission
- The Official Community Visitor Scheme

Question 21: To which bodies should the Senior Practitioner have the power to share information and in what circumstances should the Senior Practitioner be permitted to share information?

IDRS believes that the bodies to which the Senior Practitioner should have the power to share information might include:

- The NDIS Quality and Safeguards Commission, in circumstances where there are findings of non-compliance or misconduct against a service provider, for example;
- NSW Police, in circumstances where there is evidence of criminal behaviour or the individual was at significant risk;
- Hospitals, in circumstances where the individual with a restrictive practice was hospitalised;
- Justice Health and Forensic Mental Health Network (Justice Health NSW), in circumstances of forensic medical intervention.

Question 22: Are the means by which the Senior Practitioner would have visibility of the use of restrictive practices by NDIS providers proposed in this Paper sufficient? If not, what additional information should providers be required to report to the Senior Practitioner? How can reporting burden to the Senior Practitioner and the NDIS Commission be minimised?

As noted above, our view is that the Senior Practitioner should be aware of authorisations under the two-step model. Any monitoring that relies on self-reporting by providers is unlikely to effectively safeguard against the misuse of restrictive practices.

In response to the second question, we believe that staff development and capacity-building costs should be built into the NDIS funding model. Often, providers absorb these costs. And for small providers, increased compliance requirements might have the effect of pushing them out of the market, without due regard for the quality of their service. The market should provide for both large scale and smaller

ABN 11 216 371 524
PO Box 20228, World Square NSW 2002
• P 1300 665 908 • P 02 9265 6300 • F 02 9265 6333
www.idrs.org.au

providers to suit the needs of people with disability, especially for those people living in underserviced markets. However, organisations funded to provide NDIS services should be required to demonstrate their capacity to meet compliance and reporting requirements as part of their safety framework.

The ACT Review reported that disability service providers 'strongly expressed the view that reporting was time-consuming', 'onerous' and 'burdensome', with a disability peak organisation submitting that some service providers reported employing multiple full-time staff to meet the statutory reporting obligations.[16]

Question 23: Do you agree the Senior Practitioner should have the proposed education and guidance functions?

Yes. As suggested above, a well-trained and well-resourced sector should be viewed as a precondition to implementing the proposed framework, and to enabling broader cultural change. We believe that the education and guidance functions should extend to:

- providers;
- NDIS participants and their carers;
- relevant legal practitioners;
- relevant medical professionals.

At a minimum, education and training should be rights-based and should:

- define key terms, core principles and provide examples of restrictive practices and supported decision making;
- set out strategies and practices to help implement supported decision-making;
- set out preventive strategies and response strategies to address the behaviours of concern that do not require restrictive practices and authorisation.

Question 24: Should the Senior Practitioner have the power to impose sanctions for the misuse of restrictive practices, or are existing sanctions for misuse of restrictive practices sufficient? How should the interaction between sanctions provided for under NDIS legislation and the proposed framework be managed?

IDRS notes that sanctions can deter the misuse of restrictive practices and believes the Senior Practitioner should, where applicable, be obligated to:

- report providers to the NDIS Quality and Safeguards Commission;
- report criminal behaviour to the police to consider prosecution under existing criminal law;
- refer individuals to solicitors for civil or criminal action.

[16] *ACT Review* (n 12) 36.

ABN 11 216 371 524
PO Box 20228, World Square NSW 2002
• P 1300 665 908 • P 02 9265 6300 • F 02 9265 6333
www.idrs.org.au

Question 25: Should the proposed framework provide for a legislated immunity from liability from the use of restrictive practices where the use was in accordance with an authorisation and done in good faith?

No. IDRS does not believe good faith provisions should apply to service providers because, as independent businesses, they should not benefit from treatment different to all other persons or corporations under New South Wales law. Insurance is available for businesses and small providers to mitigate risks of this nature. Further an act of 'good faith' is interpretive and subjective and, if legislated, may not provide a person with disability review and appeals rights.

Question 26: Are there any other functions which the Senior Practitioner should have? Should providers in the disability service provision setting be subject to any other requirements?

As noted above, IDRS considers that the Office of the Senior Practitioner could oversee a professional accreditation process or similar.

Thank you for considering our submission. Should you have any questions, please do not hesitate to contact us at info@idrs.org.au.

Sincerely

Joanne Yates

Joanne Yates – Chief Executive Officer

ABN 11 216 371 524
PO Box 20228, World Square NSW 2002
• P 1300 665 908 • P 02 9265 6300 • F 02 9265 6333
www.idrs.org.au