

Policy Position Statement: Secure Care in Queensland

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Purpose

This policy position statement sets out the Commissioner’s governance-focused, rights-based assessment of proposals described as “secure care” for children and young people in Queensland. It examines such proposals through the lens of sound public policy, system design and accountability, grounded in binding international human rights law and authoritative UN treaty body interpretation, including the United Nations Convention on the Rights of the Child (UNCRC) General Measures of Implementation,¹ the principle of the enduring best interests of the child, and the preventive framework of the Optional Protocol to the Convention against Torture (OPCAT).

The statement is informed by established policy and practice guidance from UNICEF, Save the Children, and the International Committee of the Red Cross (ICRC), and is situated within Queensland’s statutory, human rights and oversight framework. It assesses secure care proposals against principles of the best interests of the child as a continuing and future-oriented obligation, community safety, necessity, proportionality, prevention of harm, transparency and independent oversight, with a particular focus on whether such models support children’s long-term safety, development, dignity and life outcomes, or instead entrench harm, dependency or systemic risk.

System design and prevention

This position is grounded first and foremost in the general measures of implementation required under Article 4 of the UNCRC. These measures require States not only to refrain from violating children’s rights, but to design legislative, policy, governance and budgetary systems that prevent foreseeable harm and progressively realise children’s rights.

General Measures encompass:

- legislative and policy architecture;
- institutional design and governance;
- budgetary allocation and prioritisation;
- workforce capability;
- data collection, monitoring and accountability; and
- access to remedies.

¹ UN Committee on the Rights of the Child, *General Comment No. 5 (2003): General Measures of Implementation of the Convention on the Rights of the Child*, UN Doc CRC/GC/2003/5, paras 1–2, 7–9, 12–13, 19–21.

The Child Safe Organisations Act 2024 (Qld) requires systems to be designed to prevent harm by addressing foreseeable structural risks,² not merely to respond after harm has occurred. Closed, coercive or highly restrictive care environments engage elevated safeguarding risks by their nature and are therefore inconsistent with system design that is conducive to, and preserves, the primacy of the paramount principle in policy and practice. Where environments concentrate power, restrict exit and reduce external scrutiny, they undermine the capacity of decision-makers and practitioners to give ongoing, genuine primacy to the best interests of the child, and instead normalise risk, control and institutional convenience as drivers of practice.

From this perspective, the central question is not whether an individual placement described as “secure care” could be rendered compliant through safeguards. The question is whether embedding deprivation of liberty into service architecture is compatible with a rights-based system design.

From a best interests perspective, system design choices must be assessed not only by their immediate capacity to manage risk, but by their foreseeable and cumulative impact on children’s safety, development, autonomy and life trajectories. A system that plans for confinement rather than prevention fails to give primary consideration to children’s enduring best interests, because it embeds pathways that predictably expose children to coercion, dependency and institutional harm.

Secure care proposals typically arise where upstream systems have failed: where disability supports are unavailable, mental health services are inaccessible, housing is unstable, or family-based and community care are under-resourced. In such circumstances, confinement functions as a mechanism for managing unmet need rather than addressing it.³

Under Article 4 of the UNCRC, this constitutes a failure of general measures. States are required to use the maximum extent of available resources to prevent escalation into rights-restricting responses. Designing a secure care pathway reverses this logic, planning for deprivation of liberty rather than preventing it.

² Child Safe Organisations Act 2024 (Qld), ss 8–10 (child safe standards), s 12 (preventive approach to safeguarding and risk management).

³ UNICEF, *Child Protection Strategy 2021–2030*; UNICEF, *A Rights-Based Approach to Child Protection Systems*(2018); UNICEF Innocenti, *Children in Detention: Evidence on the Effects of Deprivation of Liberty* (2018); UN Committee on the Rights of the Child, *General Comment No. 5 (2003) on General Measures of Implementation*, UN Doc CRC/GC/2003/5, paras 7–9, 12–13, 19–21.

Terminology and analytical approach

The term “*secure care*” is used in this statement solely to reflect prevailing policy language. It is not a term recognised in international human rights law.

A child is deprived of liberty where they are not free to leave a placement at will, regardless of the purpose, label, or system pathway through which the placement occurs.⁴ Where a child’s movement, association or exit is restricted by or with the consent of a public authority, the placement constitutes deprivation of liberty in substance, irrespective of whether it is framed as welfare, protection, therapy, rehabilitation or care.

The pairing of the terms “*secure*” and “*care*” risks conflating confinement with care, obscuring the exercise of coercive state power and diminishing the visibility of the strict legal safeguards that must apply.

Framing deprivation of liberty as “*care*” is also incompatible with a best interests analysis, as it redefines coercion as protection and risks normalising restrictions that undermine children’s sense of agency, trust in adults, and long-term developmental wellbeing.⁵

International human rights architecture governing secure care (see Annex A)

Proposals described as “*secure care*” must be assessed against the full suite of applicable international human rights obligations, read together and applied cumulatively, rather than by selective reliance on individual instruments. These obligations operate as an integrated accountability architecture governing how States respond to risk affecting children.

This framework applies not only to the physical environments in which children may be placed, but also to the authorisation and use of restrictive practices and coercive powers by State-funded service providers, including restraint, seclusion, isolation and other liberty-limiting interventions.⁶ From a human rights perspective, the legal character of a measure is determined by its effect on the child, not by how it is

⁴ UN Committee on the Rights of the Child, *General Comment No. 24 (2019) on children’s rights in the child justice system*, UN Doc CRC/C/GC/24, paras 10–12; UN Working Group on Arbitrary Detention, *Deliberation No. 5 on deprivation of liberty of migrants*, UN Doc A/HRC/13/30, Annex II, para 7; European Court of Human Rights, *Guzzardi v Italy* (1980) 3 EHRR 333, paras 92–93.

⁵ UN Committee on the Rights of the Child, *General Comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration*, UN Doc CRC/C/GC/14, paras 6, 58–63, 79–80; UNICEF, *A Rights-Based Approach to Child Protection Systems* (2018); UNICEF, *Child Protection Strategy 2021–2030*.

⁶ UN Committee on the Rights of the Child, *General Comment No. 24 (2019) on children’s rights in the child justice system*, UN Doc CRC/C/GC/24, paras 10–12, 86–91; UN Committee on the Rights of the Child, *General Comment No. 5 (2003) on General Measures of Implementation*, UN Doc CRC/GC/2003/5, paras 12–13; Optional Protocol to the Convention against Torture (OPCAT), arts 1, 3–4; UN Subcommittee on Prevention of Torture, *Guidelines on National Preventive Mechanisms* (CAT/OP/12/5).

labelled, the setting in which it occurs, or whether it is carried out by a government agency or a contracted provider.

At the centre of this framework is the UNCRC, which establishes children as rights-holders and States as primary duty-bearers. The UNCRC requires that the best interests of the child be a primary consideration in all actions affecting children, that deprivation of liberty be used only as a measure of last resort and for the shortest appropriate period, and that States design systems that prevent escalation into rights-restricting responses through the general measures of implementation required under Article 4. These obligations extend to legislative, policy and commissioning decisions that confer coercive authority on non-state actors; responsibility for compliance with children's rights cannot be delegated or displaced through funding, contracting or outsourcing arrangements.

OPCAT complements the UNCRC by establishing a preventive oversight framework for all places where people, including children, are deprived of liberty. OPCAT does not legitimise confinement or the routine use of restrictive practices. Its purpose is to reduce reliance on deprivation of liberty and associated coercive measures by exposing structural risk and reinforcing the imperative to avoid closed, coercive or highly controlled responses for children wherever possible.

From a child rights perspective, proposals that contemplate "secure care" must therefore be assessed in light of the State's decision to fund, authorise or permit service providers to exercise restrictive practices and coercive powers as part of care delivery. Where the State confers authority on funded providers to apply restraint, seclusion, isolation, coercive control or other liberty-limiting interventions, those providers are exercising public power that directly interferes with children's rights to liberty, bodily integrity, dignity and participation. International human rights law is clear that such powers engage the State's non-delegable duty to respect, protect and fulfil children's rights.

Authorising restrictive practices as a routine or anticipated feature of service provision therefore attracts the same strict necessity, proportionality, oversight and accountability requirements as deprivation of liberty exercised directly by the State and obliges the State to take proactive steps to ensure that coercive practices are neither normalised nor relied upon to compensate for deficiencies in service design, availability or system capacity.

For specific groups of children, additional binding and declaratory instruments apply. The Convention on the Rights of Persons with Disabilities (CRPD) provides that the existence of a disability shall in no case justify a deprivation of liberty, requiring supported decision-making, reasonable adjustments and community-based supports in place of coercive control. The United Nations Declaration on the Rights of Indigenous Peoples

(UNDRIP)⁷ affirms Indigenous self-determination, cultural authority, protection from forced assimilation, and the right of Indigenous children to maintain connection to family, community and Country, including through free, prior and informed consent in matters affecting Indigenous peoples collectively.

Read together, these instruments significantly narrow, and in many cases effectively preclude the lawful policy space not only for secure care environments, but for statutory frameworks that authorise or normalise restrictive practices as a system response. They establish that confinement and coercive interventions cannot be justified as substitutes for adequate services, as responses to disability or trauma, or as mechanisms for managing structural or workforce risk. Instead, they require States to design child protection systems that are preventive, non-discriminatory, community-based and oriented toward reducing, rather than legitimising, deprivation of liberty and restrictive practices.⁸

Core position

Secure care should be prohibited as a routine or standing system response where it involves restriction of liberty. International human rights law establishes a strong presumption against deprivation of liberty, particularly for children. Deprivation of liberty is not regulated as a neutral or therapeutic intervention; it is treated as an exceptional, inherently high-risk measure that must be actively reduced and ultimately eliminated, including because of its disproportionate impact on children who are already marginalised.

This presumption reflects two foundational principles of international law. First, that the best interests of the child must be a primary consideration in all actions affecting children. Second, that restrictions on liberty must never be justified by administrative convenience, service gaps, workforce shortages, or group-based assumptions about risk. Measures that rely on confinement as a form of care are incompatible with a best-interests assessment where less restrictive, rights-respecting alternatives are available.

Importantly, the best interests of the child cannot be invoked at a general or population level to justify confinement-based models. International law requires a concrete, child-specific and future-oriented assessment, which closed or coercive settings are structurally incapable of providing.⁹

⁷ United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), GA Res 61/295 (2007), arts 3, 7, 8, 18, 19, 21 and 22.

⁸ UN Committee on the Rights of the Child, *General Comment No. 5 (2003) on General Measures of Implementation*, UN Doc CRC/GC/2003/5, paras 7–9, 12–13, 19–21; UN Committee on the Rights of the Child, *General Comment No. 24 (2019) on children's rights in the child justice system*, UN Doc CRC/GC/24, paras 10–12, 86–91; Convention on the Rights of Persons with Disabilities (CRPD), arts 14 and 19; UNICEF, *Child Protection Strategy 2021–2030*.

⁹ UN Committee on the Rights of the Child, *General Comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration*, UN Doc CRC/GC/14, paras 1, 6, 32–33, 58–63, 79–80; UN Committee on the Rights of the Child, *General Comment No. 5 (2003) on General Measures of Implementation*, UN Doc CRC/GC/2003/5, paras 7–9, 12–13; UN Committee on the Rights of the Child, *General Comment No. 24 (2019) on children's rights in the child justice system*, UN Doc CRC/GC/24, paras 10–12, 89–91.

The Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission) found that institutional abuse and systemic harm are most likely to occur in environments characterised by isolation, dependency, significant power imbalance, restricted exit, and limited external scrutiny. Critically, the Royal Commission emphasised that institutional harm arises primarily from environmental and governance failures, not solely from individual misconduct.¹⁰ It cautioned against reliance on closed, segregated or coercive settings as protective or therapeutic responses, noting that such environments inherently amplify risk by concentrating power, reducing transparency, and weakening safeguards. Read together, international human rights law and the Royal Commission's findings underscore that confinement-based models create structural conditions of risk, particularly for children who are already vulnerable. Re-describing such settings as “care” does not mitigate these risks and does not alter their legal or human rights character.¹¹

Accordingly, any model described as “secure care” that involves confinement, restrictive practice, or coercion is prima facie incompatible with international law unless all of the following cumulative conditions are met:

- legality, with a clear, narrow and accessible statutory basis;
- non-arbitrariness, supported by evidence-based justification specific to the individual child;
- necessity, including demonstrable exhaustion of less restrictive alternatives;
- proportionality to a clearly defined and immediate risk;
- use as a genuine measure of last resort;
- application for the shortest appropriate duration;
- independent authorisation and regular, meaningful review;
- access to legal assistance and independent advocacy;
- meaningful participation of the child, with due weight given to their views;
- non-discrimination, including protection against disproportionate impact on Aboriginal and Torres Strait Islander children, children with disability and other marginalised groups; and
- independent oversight and accountability.¹²

¹⁰ Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report* (2017), Vol 1, *Our Inquiry*; Vol 6, *Making institutions child safe*, esp chs 2–3; Vol 8, *Recordkeeping and information sharing*; see also *Redress and civil litigation* Vol 11, ch 8.

¹¹ UN Committee on the Rights of the Child, *General Comment No. 13 (2011) on the right of the child to freedom from all forms of violence*, UN Doc CRC/C/GC/13, paras 33–35, 72–74; UN Committee on the Rights of the Child, *General Comment No. 14 (2013) on the best interests of the child*, UN Doc CRC/C/GC/14, paras 58–63, 79–80; Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report* (2017), Vol 6 (*Making institutions child safe*), chs 2–3.

¹² UN Convention on the Rights of the Child (UNCRC), arts 3, 12, 37; UN Committee on the Rights of the Child, *General Comment No. 14 (2013) on the best interests of the child*, UN Doc CRC/C/GC/14, paras 32–33, 58–63; UN Committee on the Rights of the Child, *General Comment No. 24 (2019) on children's rights in the child justice system*, UN Doc CRC/C/GC/24, paras 10–12, 86–91; Convention on the Rights of Persons with Disabilities (CRPD), arts 12, 14 and 19; Optional Protocol to the Convention against Torture (OPCAT), arts 1, 3–4; UN Working Group on Arbitrary Detention, *Deliberation No. 5*, UN Doc A/HRC/13/30, Annex II; UNICEF, *Child Protection Strategy 2021–2030*.

Consistent with UNICEF's policy framework, effective responses to risk must not rely on deprivation of liberty as a substitute for adequate systems, services or prevention. UNICEF does not frame children's rights and community safety as competing objectives. Rather, it emphasises that both are best served through responses that are:

- preventive, addressing structural, developmental and environmental drivers of harm before escalation;
- individualised, tailored to the child's circumstances, needs and evolving capacities;
- supportive rather than punitive, grounded in care, supervision and accountability without coercion;
- community-based, maintaining connection to family, culture and support networks; and
- designed for reduction, with a clear trajectory away from restrictive measures rather than institutional reliance.¹³

Uses of secure care that are prohibited in substance

Secure care is unlawful in substance where it:

1. Operates as welfare-based or therapeutic confinement:

Deprivation of liberty cannot be justified on protective, clinical or welfare grounds alone.

2. Responds to disability or psychosocial distress:

Disability, neurodivergence, trauma responses or "challenging behaviour" cannot lawfully justify confinement.

3. Substitutes for unavailable services:

Confinement arising from gaps in disability support, mental health care, housing or family services constitutes arbitrary detention.

4. Produces discriminatory or structural harm:

Models that disproportionately confine Aboriginal and Torres Strait Islander children, children with disability, or girls and gender-diverse children breach non-discrimination obligations and entrench inequality.¹⁴

¹³ UNICEF, *Child Protection Strategy 2021–2030*; UNICEF, *A Rights-Based Approach to Child Protection Systems*(2018); UNICEF Innocenti, *Children in Detention: Evidence on the Effects of Deprivation of Liberty* (2018).

¹⁴ UN Committee on the Rights of the Child, *General Comment No. 24 (2019) on children's rights in the child justice system*, UN Doc CRC/C/GC/24, paras 10–12, 89–91; UN Committee on the Rights of the Child, *General Comment No. 14 (2013) on the best interests of the child*, UN Doc CRC/C/GC/14, paras 32–33, 58–63; and Convention on the Rights of Persons with Disabilities (CRPD), arts 12, 14 and 19; UN Committee on the Rights of Persons with Disabilities, *General Comment No. 1 (2014) on equal recognition before the law*, UN Doc CRPD/C/GC/1; UN Committee on the Rights of Persons with Disabilities, *General Comment No. 5 (2017) on living independently and being included in the community*, UN Doc CRPD/C/GC/5; and UN Convention on the Rights of the Child (UNCRC), arts 2, 3 and 37; UN Committee on the Rights of the Child, *General Comment No. 11 (2009) on Indigenous children and their rights under the Convention*, UN Doc CRC/C/GC/11; Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), arts 2 and 5.

Exceptional circumstances and limits

Short-term crisis situations may arise involving an immediate and serious risk of harm. International human rights law permits temporary emergency restrictions on liberty only in the most narrowly defined circumstances. These are not authorisations for service models, behavioural management, or risk aversion; they are exceptional emergency derogations, intended to be rare, tightly constrained and actively reduced.

The safeguards governing such emergency measures represent minimum legal thresholds, not aspirational standards, and are contingent on the State's demonstrated capability and capacity to uphold, enforce and independently police them in practice. Where that capability cannot be reliably established, the threshold for lawful use is not met.

Accordingly, emergency restrictions on liberty are lawful only where they are:

- strictly necessary to address a clearly identified and imminent risk to the child or others;
- individually authorised by an independent decision-maker, on the basis of child-specific evidence;
- time-limited to the minimum period required to stabilise the immediate risk;
- subject to continuous, active review; and
- embedded within a clear, enforceable plan for return to voluntary, community-based care.¹⁵

Even in emergency contexts, restrictions on liberty must be assessed against the child's enduring best interests, not solely against short-term risk containment. Measures that stabilise a situation while predictably undermining a child's development, trust, dignity or long-term safety cannot satisfy a best interests assessment, regardless of immediacy.¹⁶

Experience demonstrates that where these conditions are not clearly prescribed, enforceable and independently policed, emergency exceptions rapidly become normative practice. What is framed as an exceptional safeguard is absorbed into the everyday "toolkit" available to frontline workers, including inexperienced staff, and may be deployed in response to perceived behavioural threat, staff discomfort or organisational incapacity, rather than genuine necessity.¹⁷

¹⁵ UN Committee on the Rights of the Child, *General Comment No. 24 (2019) on children's rights in the child justice system*, UN Doc CRC/C/GC/24, paras 10–12, 86–91; UN Committee on the Rights of the Child, *General Comment No. 14 (2013) on the best interests of the child*, UN Doc CRC/C/GC/14, paras 32–33, 58–63; Optional Protocol to the Convention against Torture (OPCAT), arts 1, 3–4; UNICEF, *Child Protection Strategy 2021–2030*.

¹⁶ UN Committee on the Rights of the Child, *General Comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration*, UN Doc CRC/C/GC/14, paras 1, 6, 32–33, 58–63, 79–80; UN Committee on the Rights of the Child, *General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence*, UN Doc CRC/C/GC/20, paras 15–18, 39–41; UNICEF, *Child Protection Strategy 2021–2030*.

¹⁷ UN Committee on the Rights of the Child, *General Comment No. 24 (2019) on children's rights in the child justice system*, UN Doc CRC/C/GC/24, paras 10–12, 86–91; UN Subcommittee on Prevention of Torture (SPT), *Guidelines on National Preventive Mechanisms*, UN Doc CAT/OP/12/5, paras 8–12, 47–50; UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Report on solitary confinement and restraint*, UN Doc A/66/268 (2011); Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report (2017)*, Vol 6 (*Making institutions child safe*), chs 2–3.

In such environments, deprivation of liberty risks being used coercively or punitively, particularly against children who are already traumatised, marginalised or unable to advocate for themselves. As practice drifts, thresholds steadily decline and the system loses the institutional discipline required to draw, and hold, a firm, non-negotiable line on the use of coercive interventions.

Queensland's recent experience illustrates this risk. Children assessed as unsuitable for residential care have been subjected to escalating restrictive practices, including restraint and transfer into more punitive environments, without a clear legal framework, without independent authorisation, and without meaningful opportunity to challenge or refuse the decision.¹⁸ In these circumstances, the child's lack of capacity to consent or seek remedy does not operate as a safeguard; it becomes the mechanism through which coercion is normalised.

Assertions that a formal legal framework will "fix" this problem misunderstand the nature of the risk. Where a system lacks the cultural discipline, workforce capability, service availability and independent oversight required to restrain itself, legalisation tends to stabilise and legitimise practice rather than constrain it. The result is that the treatment of children becomes regulated, in practice, through the most coercive and least rights-protective parts of the system, rather than through child-centred care and protection frameworks.

UNICEF is explicit that emergency restrictions on liberty must not evolve into standing responses and must never be used as substitutes for adequate services, prevention or workforce capacity. From a child rights perspective, the test is not whether a restriction can be technically justified in theory, but whether the system can reliably prevent drift, misuse and escalation in practice.¹⁹ Where that confidence does not exist, the use of deprivation of liberty cannot be considered compatible with children's rights, even when labelled as exceptional.

Accordingly, emergency safeguards are designed to constrain, scrutinise and eliminate deprivation of liberty over time, not to legitimise, stabilise or professionalise it as a service response. Where a system cannot demonstrate the capability and capacity to hold the exceptional line, the lawful course is not to draw the line more neatly, but to refuse the model altogether.

¹⁸ Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report* (2017), Vol 6 (*Making institutions child safe*), chs 2–3; UN Committee on the Rights of the Child, *General Comment No. 24 (2019) on children's rights in the child justice system*, UN Doc CRC/C/GC/24, paras 10–12, 86–91; UN Subcommittee on Prevention of Torture (SPT), *Guidelines on National Preventive Mechanisms*, UN Doc CAT/OP/12/5, paras 8–12, 47–50.

¹⁹ UNICEF, *Child Protection Strategy 2021–2030*; UNICEF, *A Rights-Based Approach to Child Protection Systems* (2018); UNICEF Innocenti, *Children in Detention: Evidence on the Effects of Deprivation of Liberty* (2018).

Prioritising non-custodial, community-based safety mechanisms

UNICEF's rejection of secure care is grounded in a best interests analysis that prioritises children's long-term safety, relational stability, developmental needs and community belonging, rather than short-term behavioural control. UNICEF's guidance reinforces that rejecting secure care does not require tolerating risk or abandoning accountability. Rather, it emphasises that effective safety responses for children must be delivered through rights-respecting, non-custodial frameworks, and that confinement is neither necessary nor effective in managing risk for children or protecting the community.²⁰

UNICEF recognises that behaviours associated with heightened risk are most often linked to unmet developmental, psychosocial, disability-related or environmental needs, and that responses based on control and restriction of liberty tend to escalate harm, distress and disengagement.²¹ In contrast, safety outcomes are more effectively achieved through supportive, relational and supervised responses that address the drivers of risk while maintaining connection to family, community and culture.

Accordingly, UNICEF prioritises intensive, individualised, community-based interventions tailored to the best interests and circumstances of the individual child, rather than reliance on closed settings. These responses typically include:

- **bespoke, multidisciplinary care planning**, integrating mental health, disability, education, housing and family supports;
- **structured supervision and support in community settings**, including coordinated case management, increased adult presence, mentoring and outreach;
- **restorative and relational accountability mechanisms** that address harm, support behaviour change and reinforce expectations without coercion;
- **crisis response and de-escalation support**, including mobile crisis teams and short-term stabilisation in non-locked environments; and
- **family, kinship and culturally grounded community involvement**, strengthening protective relationships and shared responsibility for safety.²²

²⁰ UNICEF, *A Rights-Based Approach to Child Protection Systems* (2018); UN Committee on the Rights of the Child, *General Comment No. 24 (2019) on children's rights in the child justice system*, UN Doc CRC/C/GC/24, paras 10–12, 86–91

²¹ UNICEF Innocenti, *Children in Detention: Evidence on the Effects of Deprivation of Liberty* (2018); and UN Committee on the Rights of the Child, *General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence*, UN Doc CRC/C/GC/20, paras 15–18, 39–41, 47–48; and Convention on the Rights of Persons with Disabilities (CRPD), arts 14 and 19; UN Committee on the Rights of Persons with Disabilities, *General Comment No. 5 (2017) on living independently and being included in the community*, UN Doc CRPD/C/GC/5.

²² UNICEF & WHO, *Helping Adolescents Thrive Toolkit* (2021); UNICEF Innocenti, *Children in Detention: Evidence on the Effects of Deprivation of Liberty* (2018).

For children with disability, neurodivergence or complex trauma histories, UNICEF emphasises the use of supported decision-making and reasonable adjustments, ensuring that perceived “risk” is not treated as a proxy for unmet support needs or used to justify restrictive responses.²³

Where a child presents an immediate and serious risk, UNICEF recognises that short-term emergency measures may be required to prevent imminent harm. Such measures must be strictly necessary, time-limited, non-punitive and non-isolating, and embedded within a clear plan for return to community-based, individualised support.²⁴

UNICEF does not support the establishment of standing closed or locked facilities as a response to risk. In its framework, community safety is achieved by strengthening the systems around the child, not by removing the child from the community.²⁵

Restraint, seclusion and isolation

Any model described as “secure care” must be assessed against international standards governing restraint, seclusion and isolation, particularly in settings where children are deprived of liberty.

International law treats restraint and isolation as high-risk practices, not neutral behavioural tools. When used beyond genuinely exceptional circumstances, they may amount to cruel, inhuman or degrading treatment, especially for children and children with disability.²⁶

Prohibition of isolation

Consistent with the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (Havana Rules), UNICEF guidance and ICRC standards:

- Solitary confinement or isolation of children is prohibited, including where described as “time out”, “separation”, “quiet rooms” or similar euphemisms, where the effect is to isolate a child against their will.
- Isolation must not be used for behaviour management, compliance, discipline, risk management or convenience.

²³ Convention on the Rights of Persons with Disabilities (CRPD), arts 5, 12 and 14; UN Committee on the Rights of Persons with Disabilities, *General Comment No. 1 (2014) on equal recognition before the law*, UN Doc CRPD/C/GC/1.

²⁴ UNICEF & WHO, *Helping Adolescents Thrive Toolkit* (2021); UNICEF Innocenti, *Children in Detention: Evidence on the Effects of Deprivation of Liberty* (2018).

²⁵ UNICEF Innocenti, *Children in Detention* (2018).

²⁶ Convention on the Rights of the Child (UNCRC), arts 19 and 37; Convention on the Rights of Persons with Disabilities (CRPD), arts 14, 15 and 16; UN Committee on the Rights of the Child, *General Comment No. 13 (2011) on the right of the child to freedom from all forms of violence*, UN Doc CRC/C/GC/13, paras 33–35, 72–74; UN Committee on the Rights of Persons with Disabilities, *Guidelines on the right to liberty and security of persons with disabilities* (2015); UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Report on solitary confinement*, UN Doc A/66/268 (2011).

This prohibition reflects the well-established evidence of serious psychological harm caused by isolation and its incompatibility with children's dignity, development and mental integrity.²⁷

Strict limits on restraint

Physical, mechanical or chemical restraint may be used only as a measure of last resort, and only where strictly necessary to prevent imminent and serious harm.

Where restraint is used, it must be:

- necessary, proportionate and time-limited to the shortest duration required;
- never used for punishment, discipline, compliance or convenience;
- never used as a substitute for adequate staffing, training or therapeutic support; and
- applied with regard to the child's age, disability, trauma history and health, avoiding techniques that cause pain, humiliation or risk of injury.²⁸

Routine, anticipatory or behaviour-management use of restraint is incompatible with international standards.

Children with disability or experiencing trauma, First Nations children and girls

For children with disability, neurodivergence or complex trauma histories, the use of restraint or isolation raises heightened and compounding legal concerns. Under the CRPD, coercive practices that respond to disability-related behaviours constitute discrimination in substance, particularly where behaviour arising from distress, communication difference or unmet support needs is treated as risk warranting control rather than as a trigger for support.²⁹

²⁷ United Nations Rules for the Protection of Juveniles Deprived of their Liberty (Havana Rules), GA Res 45/113 (1990), rules 44–46; UN Committee on the Rights of the Child, *General Comment No. 24 (2019) on children's rights in the child justice system*, UN Doc CRC/C/GC/24, paras 89–91; UNICEF, *Child Protection Strategy 2021–2030*; International Committee of the Red Cross (ICRC), *Institutional care of children* (2017); UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Report on solitary confinement*, UN Doc A/66/268 (2011).

²⁸ Convention on the Rights of the Child (UNCRC), arts 19 and 37; Convention on the Rights of Persons with Disabilities (CRPD), arts 14, 15 and 16; UN Committee on the Rights of the Child, *General Comment No. 13 (2011) on the right of the child to freedom from all forms of violence*, UN Doc CRC/C/GC/13, paras 33–35, 72–74; UN Committee on the Rights of the Child, *General Comment No. 24 (2019) on children's rights in the child justice system*, UN Doc CRC/C/GC/24, paras 86–91; UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Report on solitary confinement and restraint*, UN Doc A/66/268 (2011); UN Committee on the Rights of Persons with Disabilities, *Guidelines on the right to liberty and security of persons with disabilities* (2015).

²⁹ Convention on the Rights of Persons with Disabilities (CRPD), arts 5, 12, 14 and 19; UN Committee on the Rights of Persons with Disabilities, *General Comment No. 1 (2014) on equal recognition before the law*, UN Doc CRPD/C/GC/1; UN Committee on the Rights of Persons with Disabilities, *Guidelines on the right to liberty and security of persons with disabilities* (2015); UN Committee on the Rights of Persons with Disabilities, *General Comment No. 5 (2017) on living independently and being included in the community*, UN Doc CRPD/C/GC/5.

International law requires reasonable adjustments, de-escalation and supported decision-making, not behavioural control. These obligations reflect the CRPD's rejection of practices that substitute coercion for accommodation and support.³⁰ The use of restraint or isolation in response to disability-related distress is therefore inconsistent with CRPD obligations, regardless of the setting in which it occurs.

These legal concerns are reinforced by the findings of the Royal Commission, which identified that children with disability are significantly overrepresented in institutional settings and disproportionately subjected to restrictive and harmful practices. The Royal Commission found that institutional environments amplify risk for children with disability due to dependency, power imbalance, limited communication supports, reduced capacity to complain, and heightened exposure to control-based practices, and that these risks arise from systemic and environmental failures, not from the children themselves.³¹ In this context, restraint and isolation operate not as protective measures, but as mechanisms that compound vulnerability, silence disclosure and entrench institutional harm.

The findings of the Royal Commission into Violence, Neglect, and Exploitation of People with Disability further reinforce the incompatibility of restrictive practices with international law, and recommend Australia end legal authorisation for the use of restrictive practices. The report, *Restrictive practices: A pathway to elimination* examined the lifelong harm and trauma caused by the use of restrictive practices against children and adults with disability, highlighting the disproportionate use of restrictive practices against First Nations peoples with disability and girls with disability.³² The disproportionate use of secure care for these cohorts is observed in Victoria's secure care model, where the majority of admissions are for girls, and 20 to 30 per cent of admissions are for First Nations children.³³

Safeguards and accountability

Where restraint is used in genuinely exceptional circumstances, the following safeguards are mandatory:

- authorisation, documentation and justification against necessity and proportionality thresholds;
- immediate monitoring of the child's physical and psychological wellbeing;
- support for the child to express their views following the incident;

³⁰ Convention on the Rights of Persons with Disabilities (CRPD), arts 5, 12, 14 and 19; UN Committee on the Rights of Persons with Disabilities, *General Comment No. 1 (2014) on equal recognition before the law*, UN Doc CRPD/C/GC/1; UN Committee on the Rights of Persons with Disabilities, *General Comment No. 5 (2017) on living independently and being included in the community*, UN Doc CRPD/C/GC/5; UN Committee on the Rights of Persons with Disabilities, *Guidelines on the right to liberty and security of persons with disabilities* (2015).

³¹ Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report* (2017), Vol 3 (*Impacts*), ch 6 (*People with disability*); Vol 6 (*Making institutions child safe*), chs 2–3.

³² Royal Commission into Violence, Neglect and Exploitation of People with Disability, *Restrictive Practices: A pathway to elimination*, ch 4 (*Systemic drivers and enablers of restrictive practices*).

³³ Kate Crowe, (2022), *Unlocking Doors: Learning from alternatives to secure care in Scotland, the Netherlands, Canada and Hawaii*, Winston Churchill Trust, <https://www.churchilltrust.com.au/fellow/kate-crowe-vic-2022/>

- prompt notification of parents, carers or guardians;
- independent review and access to complaints mechanisms; and
- collection and public reporting of disaggregated data to support reduction and elimination.³⁴

Failure to meet these safeguards may render restraint unlawful, even where initially justified.

Implications for secure care models

Models of care that anticipate, normalise or rely on restraint or isolation to function are structurally incompatible with international law, regardless of therapeutic framing.

International standards require systems to be designed so that restraint and isolation are unnecessary, not merely regulated.³⁵ Where a model depends on coercive practices to maintain order or manage distress, this is evidence that the model itself should not be established.

Implications for Queensland decision-makers

For Queensland decision-makers, proposals described as “secure care” must be assessed not only against international human rights standards, but against binding domestic governance, human rights and safeguarding obligations. These obligations operate together and impose clear constraints on policy design, service architecture and resource allocation.

Child Protection Act 1999 (Qld): paramount principle, least intrusive intervention and system purpose

The *Child Protection Act 1999 (Qld)* (the Act) establishes a statutory framework in which the safety, wellbeing and best interests of the child are paramount, and in which State intervention must be necessary, proportionate and the least intrusive intervention consistent with the child’s protection. The Act is directed toward supporting children to grow up safely within their families and communities wherever possible, and

³⁴ Convention on the Rights of the Child (UNCRC), arts 3, 12, 19 and 37; Convention on the Rights of Persons with Disabilities (CRPD), arts 12, 14, 15 and 16; UN Committee on the Rights of the Child, *General Comment No. 13 (2011) on the right of the child to freedom from all forms of violence*, UN Doc CRC/C/GC/13, paras 33–35, 72–74; UN Committee on the Rights of the Child, *General Comment No. 24 (2019) on children’s rights in the child justice system*, UN Doc CRC/C/GC/24, paras 86–91; Optional Protocol to the Convention against Torture (OPCAT), arts 1, 3–4; UN Subcommittee on Prevention of Torture (SPT), *Guidelines on National Preventive Mechanisms (CAT/OP/12/5)*.

³⁵ UN Committee on the Rights of the Child, *General Comment No. 13 (2011) on the right of the child to freedom from all forms of violence*, UN Doc CRC/C/GC/13, paras 33–35, 72–74; UN Committee on the Rights of the Child, *General Comment No. 24 (2019) on children’s rights in the child justice system*, UN Doc CRC/C/GC/24, paras 86–91; UNICEF, *Child Protection Strategy 2021–2030*; UNICEF Innocenti, *Children in Detention: Evidence on the Effects of Deprivation of Liberty* (2018); UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Report on solitary confinement and restraint*, UN Doc A/66/268 (2011).

places emphasis on prevention, family support, early intervention and reunification, rather than containment or control.

From this perspective, proposals that rely on secure or closed care environments, or that authorise the routine use of restrictive practices, sit uneasily with the Act's core objects and principles. Models that restrict liberty in response to behavioural distress, disability-related needs or system incapacity risk displacing the statutory focus from protection and support toward risk management and control and undermine the requirement that intervention be individually justified and no more intrusive than necessary.

The Act also contemplates that decision-making affecting children must be child-specific, evidence-informed and subject to appropriate oversight, rather than driven by service availability or administrative convenience. Where deprivation of liberty or restrictive practices are proposed as responses to unmet support needs, workforce shortages or placement scarcity, this represents a departure from the Act's intent and risks normalising system-driven intrusion in place of child-centred protection.

For Queensland decision-makers, this means that the Act does not provide a neutral or permissive foundation for secure care models. Rather, it reinforces the obligation to address risk at its source, through adequate family support, disability and mental health services, culturally appropriate responses and community-based care and to avoid embedding highly intrusive measures that are inconsistent with the Act's protective, preventive and least-intrusive orientation.

Human Rights Act 2019 (Qld): proportionality and justification

Under the *Human Rights Act 2019 (Qld)*, any decision, policy or legislative proposal that limits a child's rights must be demonstrably justified. This requires decision-makers to establish that:

- the limitation pursues a legitimate and compelling objective;
- the measure is rationally connected to that objective;
- less restrictive alternatives have been genuinely considered and exhausted; and
- the limitation is necessary and proportionate in light of the rights affected.

Service gaps, workforce shortages, funding constraints or administrative convenience cannot satisfy the proportionality test. Where deprivation of liberty is proposed in response to unmet disability, mental health, housing or family support needs, the limitation will ordinarily fail justification because the rights-restricting measure addresses the consequences of system failure rather than the source of risk.

Child Safe Organisations Act 2024 (Qld): structural risk and safeguarding

The *Child Safe Organisations Act 2024 (Qld)* requires systems to be designed to prevent harm by addressing foreseeable structural risks, not merely to respond after harm has occurred. Closed, coercive or highly restrictive care environments engage elevated safeguarding risks by their nature.³⁶

Such environments concentrate power over children, restrict freedom of movement and exit, reduce visibility, limit contact with family and community, weaken informal oversight, and normalise control-based practices. These characteristics are recognised risk factors for abuse, neglect and ill-treatment and cannot be fully mitigated through policy, training or compliance mechanisms alone.³⁷

For Queensland decision-makers, these findings mean that the creation of secure or closed care environments for children constitutes a risk decision in itself, engaging heightened safeguarding responsibilities. Child safe standards function as preventive risk-mitigation mechanisms, not as authorisation for confinement. Compliance with the *Child Safe Organisations Act 2024* cannot neutralise the inherent risks created by institutional design choices that prioritise restriction, control and segregation.

Budgetary and service design obligations

Queensland decision-makers are also bound by obligations of sound public administration and responsible resource allocation, informed by Article 4 of the UNCRC and reflected in domestic governance expectations. These obligations require the State to:

- prioritise investment in early, community-based and disability-responsive supports;
- design systems that prevent escalation into rights-restricting interventions; and
- avoid embedding deprivation of liberty as a standing feature of service architecture.

Allocating public resources to secure care models in circumstances where risk is driven by unmet support needs represents a misalignment of policy design and public expenditure. It shifts investment toward high-cost, high-harm responses while entrenching the very system failures that generate risk.

³⁶ Child Safe Organisations Act 2024 (Qld), ss 8–10, 12 (child safe standards and duty to prevent harm); Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report* (2017), Vol 6 (*Making institutions child safe*), chs 2–3; UN Committee on the Rights of the Child, *General Comment No. 13 (2011) on the right of the child to freedom from all forms of violence*, UN Doc CRC/C/GC/13, paras 33–35, 72–74.

³⁷ Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report* (2017), Vol 6 (*Making institutions child safe*), chs 2–3; UN Committee on the Rights of the Child, *General Comment No. 13 (2011) on the right of the child to freedom from all forms of violence*, UN Doc CRC/C/GC/13, paras 33–35, 72–74; UN Subcommittee on Prevention of Torture (SPT), *Guidelines on National Preventive Mechanisms*, UN Doc CAT/OP/12/5, paras 8–12, 47–50.

Combined effect

The combined effect of the *Child Protection Act 1999* (Qld), the *Human Rights Act 2019* (Qld) and the *Child Safe Organisations Act 2024* (Qld) is to require that responses to risk affecting children be child-specific, least intrusive, demonstrably justified, and designed to prevent foreseeable harm through system capacity rather than control.

Within this framework, confinement and coercive interventions cannot be justified as substitutes for adequate services, as responses to disability or trauma, or as mechanisms for managing structural or workforce risk. Instead, decision-makers are required to design child protection systems that are preventive, non-discriminatory, community-based and oriented toward reducing, rather than legitimising, deprivation of liberty and restrictive practices.³⁸

Any proposal for secure care that cannot satisfy these combined obligations ***should not proceed***.

³⁸ UN Convention on the Rights of the Child (UNCRC), arts 3, 4 and 37; UN Committee on the Rights of the Child, *General Comment No. 5 (2003) on General Measures of Implementation*, UN Doc CRC/GC/2003/5, paras 7–9, 12–13, 19–21; UN Committee on the Rights of the Child, *General Comment No. 24 (2019) on children's rights in the child justice system*, UN Doc CRC/C/GC/24, paras 10–12, 86–91; Convention on the Rights of Persons with Disabilities (CRPD), arts 14 and 19; UNICEF, *Child Protection Strategy 2021–2030*; UNICEF Innocenti, *Children in Detention: Evidence on the Effects of Deprivation of Liberty* (2018).

Annex A: Relevant UN General Comments and Authoritative Standards

Instrument	Key content	Relevance to “secure care”
UN Committee on the Rights of the Child – General Comment No. 24 (2019) on children’s rights in the child justice system	Establishes that deprivation of liberty must be a measure of last resort, for the shortest appropriate period, and subject to strict safeguards. Applies to all forms of deprivation of liberty, not only criminal detention.	Confirms that welfare-based or therapeutic confinement constitutes deprivation of liberty in substance and is subject to the same high threshold as youth detention. Undermines any attempt to create a parallel “secure care” pathway with weaker safeguards.
UN Committee on the Rights of the Child – General Comment No. 20 (2016) on adolescence	Emphasises adolescents’ evolving capacities, heightened vulnerability to coercive control, and the need for participation, autonomy and dignity. Warns against punitive or control-oriented responses to adolescent behaviour.	Secure care models that rely on control, coercion or restriction of movement are inconsistent with the developmental and participatory requirements articulated for adolescents.
UN Committee on the Rights of the Child – General Comment No. 12 (2009) on the right of the child to be heard	Requires that children be able to express views freely, without coercion, and that those views be given due weight. Participation must be genuine, safe and influence outcomes.	Closed or coercive environments structurally impair free expression and undermine genuine participation, calling into question the compatibility of secure care with Article 12 obligations.
UN Committee on the Rights of the Child – General Comment No. 13 (2011) on freedom from violence	Establishes that States must prevent all forms of violence, including institutional violence, through system design, oversight and accountability. Recognises heightened risks in institutional settings.	Reinforces that closed settings for children are inherently higher-risk and require prevention through avoidance, not merely regulation.
UN Committee on the Rights of the Child – General Comment No. 14	Clarifies that “best interests” cannot be invoked abstractly to justify rights-restricting measures	Counters claims that secure care can be justified generically as being “in the child’s best interests”

(2013) on the best interests of the child	and must be assessed case-by-case, with procedural safeguards.	absent strict necessity and proportionality.
UN Committee on the Rights of the Child – General Comment No. 5 (2003) on General Measures of Implementation	Requires States to design legislative, policy, budgetary and governance frameworks that prevent rights violations and progressively realise rights. Emphasises prevention, coordination and accountability.	Secure care reflects a system-level failure under Article 4, embedding deprivation of liberty into service architecture rather than preventing escalation through adequate supports.
UN Committee on the Rights of Persons with Disabilities – General Comment No. 1 (2014) on legal capacity	Rejects substitute decision-making and emphasises supported decision-making, autonomy and dignity for persons with disability.	Secure care models that rely on substituted consent or behavioural control for children with disability conflict with CRPD principles.
UN Committee on the Rights of Persons with Disabilities – General Comment No. 5 (2017) on living independently and inclusion in the community	Establishes the right to live in the community with access to supports and rejects institutionalisation.	Reinforces that confinement or institutional placement of children with disability is inconsistent with CRPD obligations.
UN Rules for the Protection of Juveniles Deprived of their Liberty (Havana Rules)	Set minimum standards for treatment, including prohibition of solitary confinement, strict limits on restraint, access to education, health care, family contact and oversight.	Apply to any setting where children are deprived of liberty, regardless of label. Demonstrate that “secure care” cannot avoid detention-grade safeguards.
Optional Protocol to the Convention Against Torture (OPCAT)	Establishes preventive oversight of all places of deprivation of liberty, based on the premise that such places are inherently high-risk.	Confirms that any secure care facility would be a place of deprivation of liberty and subject to OPCAT scrutiny, reinforcing that avoidance of closed settings is the strongest preventive measure.