

FINAL REPORT

Independent review of Queensland's regulatory framework for positive behaviour support and restrictive practices

Disability Services

November 2020

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About the Policy Innovation Hub

The Policy Innovation Hub is a gateway for government, industry and community knowledge partnerships. It provides insights and analysis that help to shape the future of Queensland, Australia and the Asia-Pacific. Established in May 2016, the Hub promotes and facilitates close collaboration between Griffith University researchers, students and partners in industry, government and the community.

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Executive Summary

The Independent Review of Positive Behaviour Support and Restrictive Practices (the Review) was commissioned by the then Department of Communities, Disability Services and Seniors (Disability Services). A 'restrictive practice' under section 9 of the *National Disability Insurance Scheme Act 2013* means any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability.

The United Nation's (UN) Convention on the Rights of Persons with Disabilities ([2008] ATS 12) (UNCPRD) established a rights-based approach central to the justification for the regulation of the use of restrictive practices in Australian jurisdictions. The UNCPRD was a driver for the establishment of the NDIS and elements of the Convention are built in to the *NDIS Act 2013* (Cth) (NDIS Act) to give effect, in conjunction with other laws, to Australia's obligations under the UNCPRD through section 3(1)(a).

Historically, the Disability Services Act 2006 (Qld) (DSA) has provided for the regulation of the use of restrictive practices in specialist disability services funded by the state. With the staged transition to NDIS commencing in 2016, the majority of these specialist services have moved to being funded by NDIS. From the 1 July 2019, these services are now regulated by the NDIS Quality and Safeguards Commission (NDIS Commission) in relation to restrictive practices and the collection of data on the use of restrictive practices.

The introduction of the NDIS reduced the states and territories' role in disability services and clarified the separation of responsibilities between the states and territories and the Commonwealth. According to the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 (NDIS RPBS Rules), the states and territories are responsible for authorising the use of restrictive practices with the Commonwealth responsible for oversight, reporting requirements and leading work to achieve greater national consistency in relation to authorisation processes.

The roll out of the NDIS has significantly changed the landscape of disability service provision and the expectations of people with a disability resulting in a need for greater national consistency. Consequently, draft principles have been developed at a national level to guide work to achieve this greater national consistency in relation to the authorisation of restrictive practices. Implementation of these principles in Queensland would have significant implications in Queensland.

One of the primary purposes of the Review is to explore the implications of national consistency and the options to support implementation of these draft national principles. The other driver is the commencement of the Human Rights Act 2019 (Qld) (QHRA). Under the QHRA, the intent is to reduce and eliminate the use of restrictive practices for all people with a disability.

The project has involved a desktop review of the relevant literature and initial consultations with experts and key system stakeholders. This final report brings together the findings of the desktop research and the consultation and presents a series of options of reform that will support Queensland's progress towards attaining a regulatory framework that is consistent with the national NDIS framework. These options build upon the strengths of Queensland's current regulatory system.

It should be noted that it was not possible within the timeframes to conduct a comprehensive consultation process including people with a disability and their networks, and Aboriginal and Torres Strait Islanders, and people from a culturally and linguistically diverse (CALD) background. It is recommended that consultations be conducted to test the options identified in this Review as part of the development of any proposed reforms.

Key goals sought

Despite these indicators of the need for further work, the Review is confident in expressing the overarching finding that the current state authorisation process requires reform to ensure it is streamlined, easily understood and accessible; consistent with NDIS structures and oversight arrangements; and promotes a continued focus on human rights and a reduction, and ultimately elimination, of the use of restrictive practices.

Key principles

The Review identifies the key principles that should underpin any proposed reforms to at least maintain the current level of safeguards:

- the primacy of the human rights framework articulated in the QHRA.
- the complex behaviours evident in people with a disability, which are of concern because they entail a risk of harm to the person with a disability and others, can be addressed in ways that promote wellbeing by using alternative behaviour management strategies.
- a rights-based approach maximising the person with a disability's involvement, inclusion and wellbeing (UNCRPD).
- regulation that focuses on outcomes to allow people with a disability to flourish and realise their potential rather than on process.
- the independence of decision making from the service provider.
- the need for transparency and accountability.

A summary of the Review's findings is provided below.

Key findings from the literature review and legislation comparison

- Across Australian jurisdictions there is a broad consensus on the types of restrictive practices which should be regulated and with the aim to reduce and eliminate their use.
- Queensland's regulatory framework for the authorisation of restrictive practices is distinctive in the Australian context, because of the centrality of the guardianship model for the provision of consent on behalf of individuals with an intellectual disability or cognitive impairment. The other distinctive feature is the distribution of responsibility for the authorisation and review of restrictive practices across multiple agencies.
- The growth in the numbers of NDIS recipients in Queensland, the relative youth of this cohort, the predominance of people with autism and intellectual disability, coupled with evidence regarding the growing workloads of the Office of the Public Guardian (OPG) and the Queensland Civil Administrative Tribunal (QCAT), indicate that the regulatory framework is under considerable pressure and that this is likely to continue to increase.
- Other Australian jurisdictions have a more streamlined approach to the authorisation of restrictive practices. There are, however, considerable differences between the approaches adopted in other Australian jurisdictions:
 - Self-regulation by implementing providers within an agreed framework for principles: West Australia is closest to this model.

- A variant of self-regulation where the processes by which implementing providers approve the use of restrictive practices are regulated, rather than vesting authorisation in a public agency: New South Wales demonstrates this approach.
- The independence of decision making from the service provider: Victoria and Queensland are examples.
- In addition to traditional concerns to minimising regulatory burdens and costs, debates about efficacious regulation include whether regulation should:
 - focus on process, systems or outcomes
 - work through prohibitions and sanctions, or negotiation and mediation
 - distribute decision-making responsibility to intermediaries and/or other agents in the regulatory system to promote greater self-regulation.
- While there is some evidence in systematic reviews for the effectiveness of positive behaviour support (PBS) approaches to reduce the occurrence and severity of complex behaviours which may entail harm, there is little evidence about which regulatory frameworks best sponsor the use of alternatives to restrictive practices. Various regulatory frameworks in Australia have not been evaluated to determine whether and how the authorisation processes and accompanying policy frameworks induce changed practices to facilitate eliminating the use of restrictive practices.
- The concluding observations of the 2019 UN Report on Australian's implementation of the UNCRPD raised a series of concerns, inter alia, with the continued use of substitute decision-making, compulsory treatment, restrictive practices, and psychotropic medication. The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with a Disability raised similar concerns and has undertaken specific investigation into the use of restrictive practices in Australia.

Key findings from the consultation

Due to timing, COVID-19 risks and ethics approval processes, the team did not consult directly with people living with disabilities, nor those people with lived experience of restrictive practices; however, this consultation will occur in the next stage of consideration of proposed options. All that being said, the consultations revealed the breadth of experience with Queensland's regulatory system, some overlapping and some distinctive concerns, which perhaps unsurprisingly reflected the informant's position within the system. To summarise and analyse the data elicited through the consultations, a suite of principles applicable to the analysis of regulatory frameworks to advance the human rights of vulnerable populations was used.

The key findings against each of these principles are summarised below and need to be addressed in alignment the NDIS RPBS Rules:

- *Regulation protects human rights:* Participants from the different professional cultures concurred that human rights are not only advanced by procedures of authorisation that limit the use of restrictive practices, but also by the strategies to address complex behaviour. Moreover, the regulatory system must build the capability of individuals with a disability and their networks to navigate the regulatory frameworks in such a way that their perspectives are included and respected.
- *Regulation has clear purposes:* The purpose of Queensland's regulatory framework is well understood by those who appreciate its history, but not by recent market entrants. And for those with deep understanding of current authorisation processes, there is a concern that proceduralism and paperwork trumps the purposiveness of paperwork: the system focuses

more on authorisation than elimination. Incentives for greater collaboration to improve outcomes, compliance and practice reform is not clear to all players.

- *Regulation is proportionate:* Some indicated that the level of oversight for seclusion and constraint was proportionate with the seriousness of this practice. Others were concerned that differing levels of oversight and procedures for authorisation for other forms of restrictive practices caused confusion, with further confused by the introduction of the NDIS RPBS Rules and differing definitions.
- *Regulation provides accountability, transparency and accessibility:* The extent to which Queensland's regulatory framework is transparent is disputed, although some informants sufficiently familiar with the system understand and appreciate its logic. Nonetheless, there was clear concern that the regulatory framework was not accessible to non-experts or even recent market entrants, and definitely not to people with a disability and their networks. This latter insight pertained to both the definition of regulated practices and the processes through which authorisation was obtained.
- *Regulation promotes collaboration:* Consultations revealed that key stakeholders were reliant on key relationships rather than organisational protocols to ensure collaboration, despite the increasing importance of collaboration during the transition to the NDIS. With the number of stakeholders expected to continue to increase over time, this suggests that the system is vulnerable to key person risks. Informants indicated that the process of authorisation was adversarial and did not encourage collaboration to resolve issues, change practice and reduce the use of restrictive practices. This had been exacerbated during the NDIS transition with the loss of staff in Disability Services and the additional pressure placed on the OPG and QCAT. It was a source of frustration for some participants in the consultation.
- *Regulations prioritise practice reform:* Informants with deep experience recalled that there was significant emphasis on practice reform after the Carter report, as the regulatory framework was first established. The absence of systemic feedback about the progress towards the elimination of restrictive practices and the regulatory framework not seemingly to incentivise this has resulted in few practice reforms. Although, there was evidence that some providers have revisited clinical governance following the commencement of the NDIS RPBS Rules.
- *Regulations predisposes parties to compliance:* While there is a shared understanding that restrictive practices have limited efficacy and that there are better ways to advance outcomes for people with a disability who exhibit behaviours of concern, there is some confusion about jurisdictional responsibility for compliance, monitoring and evaluation of its effectiveness. This confusion makes it difficult to assess whether the implementation of positive behaviour support plans is compliant. Providers and practitioners report mixed messages between the Queensland and NDIS Commission due to the lack of consistency in definitions, which makes compliance with the specificities of regulation challenging.
- *Regulatory frameworks are supported by resources for implementation:* The availability of sufficient resources was strongly disputed and identified as a key risk in ensuring both that the use of restrictive practices was duly authorised and that strategies were adopted to limit the authorised use of restrictive practices.

Options for reform

While there is always the option to continue with current regulations, the consultations indicate multiple concerns with the operation of Queensland's regulatory framework which would provide rationale for change to be contemplated. Additionally, Queensland has agreed in principle to the draft National Principles and to working towards consistency with these principles. Given this context, the project team submits that there are three options, which are discussed in greater detail later in the report.

For all options, there is the need to clarify Queensland's approach to Locked Gates, Doors and Windows (LGDW) in the context of the NDIS. While Queensland's authorisation framework does not apply to LGDW in response to an adult with a skills deficit, it should be noted that LGDW in response to a behaviour of harm can be considered as "containment" under Queensland's definitions. Hence the Review recommends aligning the definitions of restrictive practices with the NDIS RPBS Rules, in particular, adopting the broader Commonwealth definition of environmental restraint which includes "containment" and "restricted access to objects",

All options would involve the following amendments to legislation to increase consistency with the NDIS RPBS Rules:

- Maintaining the independence of authorisation for the use of restrictive practices from the service provider
- Extending the application of the authorisation process to all NDIS participants.
- Aligning the definitions of restrictive practices with the NDIS RPBS Rules, in particular, adopting the broader Commonwealth definition of environmental restraint which includes "containment" and "restricted access to objects", and clarifying that LGDWs would fall into this category (ie LGDWs would no longer be deemed not to be a restrictive practices under Queensland framework).
- Embedding the interim/emergency authorisation system independent of the service provider and alerts about any emergency authorisations that are extended past 12 months.
- To address the requirements of the QHRA, a list of prohibited practices should be included in the DSA. At a minimum this list should include:
 - all the forms of physical restraint as prohibited by the Victorian Senior Practitioner: prone restraint, supine restraint, pin downs, take down techniques and any technique that interferes with respiration or digestion, pushed a person's head towards their chest and physical restraints that inflict pain and hyperextension of joints or pressure on joints or chest
 - the prohibitions contained in the NSW Restrictive Practices Authorisation Policy (v2.0), which includes aversion, over-correction, misuse of medication and denial of key needs.

Additionally, the Review recommends, for all options, the Chief Executive of Disability Services include in its Annual Report about trends in authorisation, particularly any cases where authorisation might continue but in a reduced application as a measure progress towards elimination of use. This may require Disability Services to collate information from QCAT as well as from its own work.

The options, however, diverge at the authorisation process:

- Option 1 (minimal level of changes, primarily maintaining a guardianship-based model with authorisation dependent on the type of restrictive practice proposed) would:
 - retain the current authorisation processes for adults with an intellectual disability and/or cognitive impairment
 - create parallel processes for all children with all forms of disability and
 - create parallel processes for adults who are not cognitively impaired.

These parallel processes would require the consent of that individual and the consent should be expressed and witnessed.

This option retains existing safeguards but would increase the complexity of the framework overall, given the current guardianship approach. If the scope of restrictive practices authorisation is expanded to include adults with a primary disability other than intellectual or cognitive disability and children with all forms of disability, the question of consent for restrictive practice use will need to be addressed carefully, as there is some uncertainty in this area of the law.

- Option 2 (medium level of changes, primarily moving away from the current guardianship-based model) would:
 - introducing a consistent streamlined authorisation approach for all proposed recipients (adults and children) irrespective of their disability type with authorisation responsibilities split between Disability Services and QCAT based on hierarchy of restrictive practices
 - shift the role of guardians (guardians for restrictive practices) in that they are to be consulted in the design and development of PBS plans, rather than provide consent.
 - Disability Services would authorise all short-term approvals and the use of mechanical and physical restraints, with an expansion of authorisation to include environmental restraints, based on clinical expertise.
 - QCAT would continue to authorise containment and seclusion given the gravity of these restrictive practices. However, given the ambiguity around LGDW (as these can be construed as containment) it may be that requests for authorisation of LGDW should also be considered by QCAT.
 - QCAT would hold oral hearings with multi-member panels with an advocate for the person with a disability present.
 - QCAT would continue undertake administrative reviews and appeals process pertaining to the restrictive practices' authorisation process as QCAT is an appropriate merits review body (whereas complaints about the delivery of NDIS supports, including restrictive practices, would continue to be directed to the NDIS Commission).
- Option 3 (**preferred**, requires legislative and process reform to result in a simpler, streamlined authorisation process more closely aligned with the approach consulted stakeholders are calling for, as well as aligned with the draft National Principles.):
 - provides a uniform authorisation process for all types of restrictive practices and for all people with a disability (adults or children), removing the hierarchy of the restrictive practices
 - appoints an appropriately qualified Authorised Officer in Disability Services who would approve all restrictive practices including short term approvals based on clinical grounds
 - Disability Services would undertake reviews promoting a step down in restrictive practices at each review
 - QCAT acts only as an appeals body given it is the appropriate appeals body
 - QCAT would hold oral hearings with multi-member panels with an advocate for the person with a disability being present.

This option would be more consistent with the models in Victoria and the Australian Capital Territory (ACT). It would allow a stronger focus on reduction and elimination, with the people making the authorisation decisions having the clinical skills, knowledge and expertise to confidently and professionally authorise in a consistent manner. The added advantage is this option provides a single point of accountability for restrictive practices.

As in the Victorian model, keeping QCAT as an appeals body would retain this important safeguard, but without the additional cost and complexity of QCAT being a primary decision-making body.

For implementation of both Options 2 and 3, regional panels could be established. These panels would need to include an advocate for the person with the disability. Delegates of the Disability Services' Authorising Officer could chair these regional panels. These delegates could work with the Disability Services sector to clarify the separation of the authorisation process (state responsibility) from the monitoring/ capability building/ reporting/ evaluation role (NDIS Commission responsibility).

Introduction

This Independent Review of Positive Behaviour Support and Restrictive Practices (the Review) was commissioned by the Department of Communities, Disability Services and Seniors (Disability Services) in late 2020.

Historically, the *Disability Services Act 2006* (Qld) (DSA) has provided for the regulation of the use of restrictive practices in specialist disability services funded by the state. A 'restrictive practice' is now defined under section 9 of the *National Disability Insurance Scheme Act 2013* as any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability.

This Review has been conducted following a period of significant transition in the Disability Services sector. Building on the United Nation's (UN) Convention on the Rights of Persons with Disabilities ([2008] ATS 12) (UNCRPD), all jurisdictions and the Commonwealth signed a Heads of Agreement in 2012 to develop a national disability scheme, the NDIS.

With the staged transition to NDIS commencing in 2016, the majority of the specialist disability services moved to being funded by NDIS. Accordingly, from the 1 July 2019, these are now regulated by the NDIS Quality and Safeguards Commission (NDIS Commission) in relation to restrictive practices and in the collection of data on the use of restrictive practices.

The introduction of the NDIS reduced the states and territories' role in Disability Services and clarified the separation of responsibilities between the jurisdictions and the Commonwealth. The States and Territories are responsible for authorising the use of restrictive practices with the Commonwealth responsible for oversight, reporting requirements and leading work to achieve greater national consistency in relation to authorisation processes, as per the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 (NDIS RPBS Rules).

With the commencement of the NDIS Commission in Queensland in July 2019, and the commencement of the Human Rights Act 2019 (Qld) (QHRA), the regulatory environment in which disability service providers operate has altered with specific implications for the regulation of the authorisation, use and monitoring of restrictive practices.

The roll out of the NDIS has significantly changed the landscape of disability service provision and the expectations of people with a disability resulting in a need for greater national consistency. Consequently, draft principles have been developed at a national level to guide progress to achieve greater national consistency in relation to the authorisation. Implementation of these principles in Queensland would have significant implications in Queensland.

The primary purposes of the review are to explore the implications of national consistency and the options to support implementation of these principles, and implications of the commencement of the QHRA which has the intent to reduce and eliminate the use of restrictive practices.

This final report presents the findings of the desktop review and consultations with identified stakeholders, with a view to the early identification of options for reform. It was not possible within the timeframes to conduct a comprehensive consultation process to include people with a disability and their networks, Aboriginal and Torres Strait Islanders, and people from a culturally and linguistically diverse (CALD) background. These consultations will be conducted to test any proposed options as part of the next stage of any reforms.

Purpose

The purpose of the Review is to consider the practical application of Queensland's authorisation process for regulated restrictive practices in light of the operation of the NDIS Commission in Queensland and the development of the draft national principles. The Review seeks to: identify how to preserve and enhance the strengths of the current system, consider opportunities to streamline and improve associated processes, and identify any issues and challenges associated with the proposed adoption of the draft National Principles and consistent authorisation processes. The Review has had regard for both local and international human rights instruments, pertinent legislation as well as the broader policy context. The Terms of Reference for the Review is at the Appendix.

Research methodology

The Review has involved a literature review and a legislation comparison to inform consultation with key stakeholders, and analysis of the consultation findings.

The literature review canvassed the following topics in the scholarly literature: developments and debates about the application of a human rights perspective to disability policy and service provision; developments in case law regarding the human rights of people with a disability; analysis of the impact of restrictive practices on people with a disability, and systematic reviews of the efficacy of positive behaviour support. Additionally, the project team reviewed the grey literature to reconstruct the recent history of Australian policy debates about the elimination of restrictive practices and substitute decision-making and guardianship. The project team reviewed regulatory frameworks operative in other Australian jurisdictions, alongside associated documents developed by state authorities to advise service providers and practitioners about the authorised use of restrictive practices and positive behaviour support. The project team also had access to confidential, background documents supplied by the Disability Services.

The consultation phase of the research was conducted through semi-structured interviews and focus groups informed by the literature review and legislative comparison and the Terms of Reference for the review. Ethics approval was sought and obtained from Griffith University (2020/637). The consultation involved 34 individuals including representatives from Queensland Government departments, the National Disability Insurance Agency, academics, advocates, clinical practitioners and service providers. 10 people were interviewed individually, and the remainder participated in focus groups of between two and five people. All interviews and focus groups were recorded with written consent and interpreted in ways that protected participants' rights to privacy and confidentiality.

The public servants who were either interviewed or participated in a focus group had been identified for participation by Disability Services. The sampling strategy for the remainder involved purposive selection and a snowballing strategy, whereby information about the opportunity to participate in a focus group was shared through professional networks and a community of practice hosted by National Disability Services (NDS) to identify willing participants. The shift from a purposive to a snowballing sampling strategy took place after the project began, given the tight time frames in which the research was conducted, to ensure participation from all identified stakeholder groups. As data collection progressed and the team engaged with individuals who had insights into particular parts of the regulatory framework, the questions were to elicit relevant information.

The interviews and focus groups took place over a two-week period at the end of August and the beginning of September. All were conducted online using either Microsoft Teams or teleconferencing facilities. These interviews and focus groups were analysed, and themes identified. These themes were tested with the Disability Services' PBS and Restrictive Practices Reference Group on 2 October 2020; the majority of the members of this reference group had participated in the interviews and focus group.

Strengths and limitations of the research design

A more comprehensive consultation process would have included people with a disability and their networks, and the inclusion of Aboriginal and Torres Strait Islanders and people from a culturally and linguistically diverse (CALD) background. However, the findings are representative of members of the Reference Group which included public servants, Statutory Officers and service providers and their peak bodies.

There was some divergence in the perspectives of the participants in consultation which is indicative of the strong professional and practice cultures among stakeholders. Nonetheless, further consultation with newer market entrants and registered NDIS providers who do not work with clients who have, but may require, authorised use of restrictive practices is also recommended.

Data on system performance, the authorisation of the use of restrictive practice and quantitative evidence of the reduction in the use of these practices by service providers and clinicians, was limited. For this reason, it was difficult to properly triangulate the findings of the consultation, although the team was able to use the scholarly and grey literature to reflect on the possible implications of findings.

Despite these limitations, the project team is confident that the research design was effective in eliciting a breadth of feedback on the operation of the regulatory framework in Queensland.

Literature review and legislation comparison

Definitions

Restrictive practices refer to a raft of interventions that restrict the rights and/or limit the freedom of movement of a person with a disability. Restrictive practices involve restraint. Sometimes this is achieved directly through forms of seclusion, containment, physical, mechanical restraint and chemical interventions. Restrictive practices, however, can also be implemented by withholding information and support, altering environments to restrict choices and creating impediments to access items, goods and services. Historically, the rationale for using such practices is usually articulated with reference to managing complex behaviours exhibited by an individual and to prevent harm either to themselves or others.

Restrictive practices according to the NDIS

Under the *National Disability Insurance Act 2013* (Cth) a restrictive practice is 'any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability' (s 9). Under the NDIS Rules 2018, s 6 provides that 'restrictive practice' includes:

- Seclusion: the sole confinement of a person with disability in a room or a physical space where voluntary exit is prevented, not facilitated, or it is implied that voluntary exit is not permitted

- Chemical restraint: the use of medication or chemical substance for the primary purpose of influencing a person's behaviour
- Mechanical restraint: the use of a device to prevent, restrict, or subdue a person's movement for the primary purpose of influencing a person's behaviour
- Physical restraint: the use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour
- Environmental restraint: the restriction of a person's free access to all parts of their environment, including items or activities

The NDIS Rules s 21 also state that restrictive practices¹ must

- be used only as a last resort in response to risk of harm to the person with disability or others, and after the provider has explored and applied evidence-based, person-centred and proactive strategies;
- be the least restrictive response possible in the circumstances to ensure the safety of the person or others and reduce the risk of harm to the person with disability or others;
- be in proportion to the potential negative consequence or risk of harm; and
- be used for the shortest possible time to ensure the safety of the person with disability or others.

Restrictive practices in Queensland

Under s 144 of the *Disability Services Act 2006* (Qld) restrictive practices include: containing or secluding the adult; using chemical, mechanical or physical restraint on the adult; or, restricting the adult's access to objects, for the purposes of responding to the behaviour of an adult with an intellectual or cognitive disability that causes harm to the adult or others. Behaviour that causes 'harm' includes behaviour which results in physical harm to the person, or a serious risk of physical harm to the person, or damage to property involving a serious risk of physical harm to the person.

The Act further defines these practices elsewhere:

- Seclude: Means physically confine the adult alone, in a room or area from which free exit is prevented in response to the adult's behaviour (s 144)
- Chemical restraint: means the use of medication for the primary purpose of controlling the adult's behaviour (s 145)
- Mechanical restraint: Means the use of a device in response to the adult's behaviour for the primary purpose of controlling the adult's behaviour (s 147)

¹ National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 Part 3 Div 2 s21 <https://www.legislation.gov.au/Details/F2018L00632>

- Physical restraint: The use, for the primary purpose of controlling the adult's behaviour, of any part of another person's body to restrict the free movement of the adult in response to the adult's behaviour (s 144)
- Contain: Means physically prevent the free exit of the adult from premises, other than by secluding the adult, in response to the adult's behaviour (s 146); however, per s 146 the adult is not contained if the adult is an adult with a skills deficit under part 8, division 2
- Restricting access: Means restricting the adult's access to an object in response to the adult's behaviour that causes harm to the adult or others to prevent the adult using the object to cause harm to the adult or others (s 144) (i.e. legislation provides locking a drawer which contains knives, or to food in a cupboard)

Notably, per s 216 of the DSA, the use of Locked Gates Doors and Windows (LGDW) to prevent physical harm to an adult with an intellectual or cognitive disability or skills deficit is not a restrictive practice so long as the act is done honestly and without negligence, and complies with service provider policy that aligns with department policy (per s 220, the department must have a policy about the LGDW under this division). However, LGDW can be construed as containment and therefore can be considered as regulated under Queensland processes.

However, the definition of an adult with a skills deficit (s 217) means an adult with an intellectual or cognitive disability who cannot safely exit premises where disability services are provided to the adult without supervision, if the only reason the adult cannot safely exit the premises without supervision is—

- (a) the adult lacks road safety skills; or
- (b) the adult is vulnerable to abuse or exploitation by others; or
- (c) the adult is unable to find his or her way back to the premises; or
- (d) another reason prescribed under a regulation.

Divergence regarding the locking of gates, doors and windows:

While Queensland does not consider the LGDW to be a restrictive practice in certain circumstances (ss 146, 216 and 217), a recent (July 2019) Behaviour Support Questions & Answers published by the NDIS provides that 'if an NDIS funded service provider implements a behaviour support plan within the home that includes locked areas or restricted access to areas, then these would be environmental restraints that are regulated restrictive practices.'

Positive Behaviour Support

Positive behaviour support (PBS) emerged in the 1990s as an alternative to aversive behaviour management for complex behaviours. These were stigmatising and degrading practices, and sometimes involved punishment and humiliation, in addition to the range of practices contemporarily designated restrictive (Repp & Singh 1990, cited in Kincaid et al. 2016). PBS, by contrast, is associated with the promotion and protection of dignity, human rights and the overall wellbeing of people with disability (Kincaid et al. 2016; Wardale et al. 2018). Across Australian jurisdictions, PBS is the preferred methodology for working with people who exhibit complex behaviours. Moreover, the majority of

Australian jurisdictions have explicitly banned the use of aversive techniques and practices relating to degradation, vilification and punishment.

NDIS documents incorporate various terms: behaviour support, positive behaviour support, behaviour intervention supports, positive behavioural supports, and specialist behavioural intervention support (Higgins, 2019). PBS is defined in the NDIS Quality and Safeguarding Framework (Department of Social Services 2017, p. 100) as:

A range of proactive strategies implemented to identify and address the underlying causes of behaviours of concern through an individual functional behavioural assessment and development of a positive behaviour support plan. Positive behaviour support strategies may include implementing changes to the environment and psychological interventions such as cognitive behavioural therapy.

The *Positive Practice Framework* (PPF) (Morris & Horner 2016, p. 425, Department of Human Services, Victoria, 2018) includes a definition of PBS: 'a multifaceted approach that builds from functional behavioural assessment of problem behaviour and generates a support plan that is both comprehensive and educative'.

Consistent with these definitions, PBS has been theorised as involving process, context and prevention elements. It is a *process* of assessment, intervention, and data-based decision making focused on understanding the behaviours and their functions; by building skills and functional competencies. By considering modification to the built environment, it helps create *supportive contexts* that support quality of life, and *prevention* and reduction of problem behaviours through constructive approaches and stakeholder engagement (Carr et al. 2002; Gore et al. 2013; Kincaid et al. 2016; LaVinga & Willis 2012). In a PBS approach, reactive strategies, such as restrictive management approaches, are considered a last resort, to be used only after all other forms of support, or non-aversive methods, have been exhausted or deemed unsuitable to ensure safety or immediate reduction in behaviours (LaVigna & Willis 2012).

The current regulatory environment

The current regulatory environment in Queensland developed following the 2006 Carter Review (*Challenging Behaviours and Disability: A Targeted Response*) of the use of seclusion and restraint by state-run health, accommodation and other disability services funded by Disability Services to modify the behaviour of adults with intellectual disability and cognitive impairments. The Carter Review was published the same year that the UNCRPD was adopted by the UN General Assembly promoting the inclusion of the voices of people living with a disability in all decisions.

It is notable that the Queensland Government committed to the principle of using the least restrictive alternative in 1982, and that the process of de-institutionalization promoted further governance of the use of restrictive practices. In the mid-1990s, the Queensland Government developed additional resources to limit the use of restrictive practices and develop alternatives, including the *System of Behaviour Support and Management Resource Manual* published by the then Disability Services Queensland in 1996. Reforms continued in the early 2000s to address the promotion of human rights for people with an intellectual disability, the design and development of accommodation and respite services, as well as the development of positive behaviour strategies to manage complex behaviours.

Carter's 2006 report recommendations aimed to advance the elimination of restrictive practices by way of:

- a legislative framework to regulate their use;

- a research agenda (in particular the establishment of a Centre for Excellence in Behaviour Support);
- associated policy and service design reforms to provide a sustainable response to housing needs, including crisis accommodation and transition into private, non-congregate accommodation; and
- a stepped process to build capability in the service sector and workforce, which would receive specialised advice from highly qualified teams located in Disability Services Queensland.

The legislative framework envisioned by Carter would ensure that the use of restrictive practices would be “prima facie unlawful unless implemented as part of a targeted service response for a particular person” (p. 150). The foundations of Queensland’s regulatory framework are contained in Carter’s recommendations that:

- any proposal for the use of restrictive practices should be contained in an individualized PBS plan which is based on a comprehensive assessment;
- such plans were to require the approval of the then Guardianship and Administration Tribunal (GAAT);
- excepting interim and emergency responses approvals would be granted for six months, and any extension of the restriction would be subject to statutory review;
- the Community Visitor Program would be empowered to monitor the use of the practice, providing reports to the relevant service provider and GAAT.

A National Framework for reducing and eliminating restrictive practices was developed in the wake of the passage of the NDIS Act and endorsed by Commonwealth, State and Territory Disability Ministers in March 2014. The Framework observed that states and territories have their own legislation and authorisation processes. It anticipated the development of a national quality and safeguards system to accompany the implementation of the NDIS, which would assume national leadership on the issue. The development of the Framework was an interim step, and its intentions have been achieved by the establishment of the NDIS Commission and the development of the NDIS RPBS Rules: The states and territories have continued responsibility for the authorisation of restrictive practices and the Commonwealth monitors and reports on use and service provider capability development. The next step towards national consistency on authorisation is embedded in the draft national principles released on 24 August 2020.

Currently Queensland authorisation processes operate alongside the national NDIS RPBS Rules. The differences between the regulatory frameworks are summarised in the table below:

Table 1

Regulatory	Queensland	NDIS
Subject of regulation	Disability Services' funded Accommodation providers, with modified process for community access and respite settings	NDIS registered service providers
People protected	Adults with intellectual and cognitive disability	Recipients of NDIS services
Definition of restrictive practices	Seclusion and containment, physical restraint, mechanical constraint, chemical restraint and restricted access to objects where behaviours might result in harm to individual or others	Seclusion and containment, physical restraint, mechanical restraint, chemical restraint, and environmental restraint Inclusive of LGDW
Authorising processes	Short-term approvals (STA) authorized by Chief Executive Disability Services or Public Guardian for seclusion and containment. Longer term authorisation is approved by the guardian approving or by QCAT providing consent (for containment and seclusion). Hereafter these arrangements are referred to as authorisation.	Compliance with state and territory process required; inclusion of practices in PBS plans
Authorising body	Multiple decision-makers in multi-step process: QCAT, Public Guardian, Chief Executive Disability Services	n/a
Accreditation processes	QCAT appoints guardians for restrictive practices	NDIS Commission accredits practitioners to undertake functional behaviour assessment and develop PBS plans and implementing providers enact PBS plans
Reporting processes	Online data collection portal (two step verification process)	PBS plan lodged with Commission Unauthorized use must be reported within 5 days – reportable incident reporting
Review processes	STA approval 6 months, can be rolled-over under exceptional circumstances Containment and Seclusion approval for maximum of 12 months Relevant Guardian appointed for up to 2 years Departmental complaints mechanism	Quality assurance through data analysis; expectation that accredited service providers review PBS plan at least annually Complaints mechanism exist

Since the introduction of the NDIS (over a three-year period commencing in June 2016), there has been a growth in the disability service sector in both the number of people receiving NDIS packages and number of service providers. This has led to a subsequent increase in the workload of agencies involved in Queensland's regulatory framework. Additionally, the practice of PBS has evolved since the introduction of NDIS and with the commencement of the QHRA.

NDIS participants

At 30 June 2020, there are 75,925 Queenslanders who are active recipients of the NDIS, including children in receipt of support from the Early Childhood Early Intervention (ECEI) service. Just over

33,000, or 43.5 per cent are receiving support for the first time. Growth is expected to continue over the next few years: it is anticipated that by 2023 there will be 110,700 active NDIS participants in Queensland. The continuing growth in the number of NDIS participants is also reflected in the increasing number of service providers operating in Queensland.

Nearly half of all participants in the NDIS are under 25 years of age. At 31 March 2020, 31.1 per cent of Queensland NDIS participants had a primary diagnosis of autism and a further 21 per cent had a primary disability of intellectual disability; an additional 8.7 per cent had an acquired brain injury or other neurological disability². Hence, nearly half of all active participants experience conditions that have been associated with complex behaviours and could possibly benefit from PBS.

Queensland OPG's 2018-19 Annual Report noted a 10 per cent increase in caseload (940 new clients). The Queensland OPG³ also registered 2058 clients with the NDIS in the 2018-19 financial year, an increase of 53 per cent in twelve months. These are indicative of an increasing workload. According to QCAT's 2019 Annual Report⁴, in the 2018-19 financial year 12 per cent of containment orders reviewed that year ceased and 11 per cent of approvals for the use of seclusion reviewed that year ended. We note that QCAT also review each year all Containment and Seclusion Plans, and so their workload relates to not only approvals for initial plans but then also review and approval each year thereafter.

In the second half of 2019, the NDIS Commission reported that it had received from 340 NDIS registered service providers over 65,000 reportable incidents nation-wide in which an unauthorised restrictive practice had occurred. These incidents comprised over 95 per cent of all reportable incidents and related to 2,436 participants. The majority of these incidents related to the use of chemical restraint (58.7 per cent). (Based on population proportions this would indicate approximately 600 participants were subject to reportable incidents occurred in Queensland). The table derived from the NDIS Commission 2020 below summarises the number of incidents from July to December 2019:

Table 2

Category	Number	Per cent
Seclusion	138	0.2
Physical	727	1.1
Mechanical	1078	1.65
Environmental	25048	38.3
Chemical	38407	58.7

Contemporary practice imperatives

The project team identified one systemic evaluation of the impact of PBS, which reviewed 12 studies (LaVinga & Willis 2012), and a second review that examined 14 studies of the outcomes of PBS training (McDonald & McGill 2013). These first found evidence that PBS is effective with severe and high-rate behaviours, and results in a distinct reduction on self-injurious behaviour, physical aggression and an overall reduction in challenging behaviours. LaVinga and Willis also found evidence that PBS can be applied effectively in both community and institutional settings. McDonald and McGill identified studies

² NDIS, <https://data.ndis.gov.au>, accessed 26 September 2020

³ Office of Public Guardian 2018-19 Annual Report, 2019

⁴ Queensland Civil and Administrative Tribunal 2018-19 Annual Report, 2019

that demonstrated that training in PBS could reduce the use of restrictive practices, although there were considerable methodological differences between the studies that they examined, with some only addressing staff knowledge and attitudes rather than practice.

The grey literature suggests that the following factors makes the use of restrictive practices more likely:

- Service and staff related factors: crisis-driven and reactive service provision; poor staff training
- Context related factors: inappropriate accommodation and/or built environment more broadly
- Support issues: limited opportunity for individuals with a disability to engage in self-expression and or access to advocacy, and
- Communication issues: ineffective communication techniques used in service delivery.

The protective factors that can facilitate the reduction of the use of restrictive practices are also reasonably well understood:

- Leadership: in particular, to develop an organisation culture committed to eliminating the use of restrictive practices
- Cultural competence: ensuring the practice is respectful of cultural differences and trauma informed
- Qualified staff: working in well-designed programs that address needs and build capacity
- Professional development: that allows staff at all levels to be familiar and comfortable with utilising alternative strategies in response to complex behaviours, and
- Appropriate built environments.

Moreover, there are some key principles that inform the practice of PBS:

- Social and rights-based models of disability: which understand that the disadvantages and forms of exclusion faced by people with a disability are reinforced and entrenched by structural and social factors; the defence and advancement of human rights can be an antidote to these forms of discrimination
- Philosophy of care: that appreciates the centrality of relationships to people's lives, that the provision of care should promote dignity and an opportunity to flourish
- Person-centred: assessment and planning must be highly individualised with interventions designed in response to individual circumstances
- Strengths-based approach: while assessment tools of necessity identify deficits and impairments, planning tools should look to build on people's strengths and capacities
- Inclusivity and cultural sensitivity: the importance of enabling active participation by people with a disability in their networks in any planning process to enable choice and control

- Collaborative implementation: with a co-ordinated approach across relevant service providers and support networks to support consistent implementation
- Evidence-based: assessment and planning should deploy contemporary evidence about which strategies and interventions are effective in different contexts

The emergence of state-based human rights legislation is another contemporary practice driver. The other Australian jurisdictions to provide statutory protection of human rights are the ACT and Victoria. The QHRA, which commenced on 1 January 2020, includes substantive rights that are of direct relevance to this Review including:

- Recognition of equality before the law (s 15)
- Protection from torture and cruel, inhuman degrading treatment (s 17)
- Right to health services, without discrimination (s 37(1)).

These principles are of particular significance because they can be abrogated in the authorisation and implementation of restrictive practices if care is not taken to ensure that active participation of people with a disability, the application of the least restrictive practice possible, and the potentially deleterious impact on community access and the health and wellbeing of individuals subjected to restrictive practices.

Additionally, the QHRA was drafted with explicit reference to the NDIS. Disability service providers registered with the NDIS, are expressly defined as a public entity (s 9(5)) which obligates providers to have consideration for human rights in action and decision-making, making it unlawful to act in ways that are incompatible with human rights or make decisions without proper consideration to the human rights relevant to the decision. The inclusion of NDIS providers as public entities under the QHRA also means that complaints about their actions, and complaints about the use of restrictive practices where these are thought to be inconsistent with human rights, can be lodged with the Queensland Human Rights Commission (QHRC). The QHRA also provides for referral of complaints to the NDIS Commission and for the QHRC to enter into an arrangement with the NDIS Commissioner about human rights complaints.

The Queensland regulatory system stakeholders include:

- the agencies and entities (such as QCAT) which are variously empowered to authorise actions and ensure compliance with the framework (regulators)
- intermediaries which may be charged with interpretation and some aspects of implementation and monitoring to strengthen the regulatory framework or may have an advisory function
- the targets who are subject to regulation and must adapt practice accordingly
- people with a disability protected by the regulation (Abbott et al. 2017).

The processes through which authorisation can be obtained in Queensland govern which agency (“the regulators”) can authorise what kind of restrictive practice, where or in which location/service, and for how long. The process for the different types of restrictive practice is summarised in the table below (noting that this does not include the additional authorisation processes required for the use of each

practice in a respite or community access service). This demonstrates the centrality of the guardianship system to the framework for authorisation in Queensland.

It is important to note that in Queensland, guardians act as substitute decision-makers. The guardians for restrictive practices are considered to have consented to the use of restrictive practices on behalf of the individual concerned. When either QCAT or the Chief Executive, delegate of Disability Services, are the relevant decision maker, they provide authorisation. In both instances this gives service providers immunity from prosecution. Families can participate throughout the process and at times are appointed as the relevant guardian for restrictive practices. Decisions made by QCAT can be appealed to the QCAT Appeals Tribunal. There are avenues to appeal a decision of the QCAT Appeal Tribunal. The DSA provides that an interested person can apply for a review of decisions made by the Chief Executive of Disability Services. It is possible to appeal a decision about the appointment of a guardian for restrictive practices even though a decision by the guardian may not be reviewable. QCAT also has the power, on application including by way of an appeal, to remove a guardian for restrictive practices.

Table 3

Restrictive Practice		Authorisation/Consent
Containment or seclusion	Short-term	Public Guardian
	Longer-term	QCAT
Mechanical restraint	Short-term	Chief Executive delegate, Disability Services
	Longer-term	Guardian for restrictive practice (consent)
Chemical restraint	Short-term	Chief Executive delegate, Disability Services
	Longer-term	Guardian for restrictive practice (consent) or relevant decision maker for fixed dose respite only
Physical restraint	Short-term	Chief Executive delegate, Disability Services
	Longer-term	Guardian for Restrictive Practices (consent)
Restricted access to objects	Short-term	Chief Executive delegate, Disability Services
	Longer-term	A guardian for a restrictive practice (general) matter for the adult; or if there is no guardian for a restrictive practice (general) matter for the adult, an informal decision-maker for the adult.

The DSA provides that following an application for a short-term approval for the use of a restrictive practice, the relevant decision-maker will communicate their decision regarding approval to the relevant provider in writing within seven days. Restrictive practices can be used by a service provider for up to 30 days once an application for short-term approval has been made, if the application has been made in writing, although this permission ceases once an initial determination has been made. If short-term authorisation has been granted, the service provider will commence a functional assessment and develop a PSB plan.

The DSA also determines who can draft a PSB plan and the number of clinical practitioners to be consulted. For seclusion and containment, the PSB plan is prepared by the Chief Executive of Disability Services; for other forms of restrictive practice this is undertaken by the service provider. The DSA also contains provisions around consultation in each instance if the individual is also under a forensic order, treatment support order or treatment authority under the *Mental Health Act 2016* (Qld) or is a forensic disability client. The DSA articulates the functions a PBS plan should serve: to advance the wellbeing, developmental and other needs of the person concerned and reduce the intensity, frequency and duration of the complex behaviours identified as causing harm.

The transition to the NDIS and the commencement of the QHRA has expanded the number of regulators; the targets of regulation (to include all regulated providers not just those providing accommodation, respite and access support); and the people with disability protected by the regulation. The people with disability protected under the NDIS RPBS Rules include children with a disability, and adults who exhibit complex behaviours who may require behaviour support but do not have cognitive impairments. To illustrate, the additional stakeholders post NDIS introduction and the QHRA are highlighted in red in the table below:

Table 4

Stakeholder	Direct inclusions	Indirect inclusions
Regulators	<p>NDIS Commission</p> <p>Disability Services' Executive and delegates</p> <p>OPG</p> <p>QCAT</p>	<p>QHRC</p>
Intermediaries	<p>Office of the Public Advocate (OPA) undertakes systemic advocacy</p> <p>Community Visitors under the Office for the Public Guardian have an 'inquiry and complaints' function in relation to 'visitable sites' as defined under the Public Guardian Act 2014</p> <p>Queensland Human Rights Commission provides training and has a complaints function under QHRA 2019</p>	<p>NDIS Local Area Coordinators (LAC) recommend the inclusion of funding to address complex behaviour and the selection of clinical support in NDIS funding plans. In some instance support coordinators have a role in the selection of clinicians.</p> <p>For those with dual diagnoses that include mental illness, autism or dementia treating psychiatrists</p> <p>Advocates and training providers are not formally recognised but nonetheless play a role in advancing the interpretation and implementation of the regulatory framework.</p>
Targets	<p>Positive behaviour and other clinical specialists who design and develop plans for authorisation.</p> <p>All registered disability service providers, not just Accommodation providers, respite and community access services</p>	<p>Implementing providers if not registered</p> <p>Providers of out of home care (OOHC) services, if they support children who also have NDIS plans</p> <p>Other sites or agencies that interact with an individual who has an approved plan, for example disability employment service providers</p>

People protected	<p>Children with a disability, and adults who exhibit complex behaviours who may require behaviour support but do not have cognitive impairments.</p> <p>People including those with an intellectual disability and/or cognitive impairment disability ought to benefit by having their rights respected and protected.</p>	<p>Family members, front-line staff and community members are also implicitly recognised as rights bearers whose safety and wellbeing should be advanced by the regulation of restrictive practices</p>
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NDIS Quality and Safeguards Commission’s regulatory framework

The NDIS Commission’s behaviour support functions are centred on the premise of individualised strategies that reduce the incidence of behaviours of concern with the goal of not requiring restrictive practices to be applied. These individualised strategies are drafted by behaviour support practitioners overseen by the NDIS Commission’s Senior Practitioner:

- monitors behaviour support practitioners and implementing service providers
- provides best practice advice to practitioners, providers, participants, families, and carers
- review service provider reports on the use of restrictive practices and on any unauthorised use of a restrictive practice (termed a “reportable incident”)
- investigates incidents that suggest there are unmet behaviour support needs
- accredit behaviour support practitioners (who assess clients, develop behaviour support plans and articulate their implementation, review progress) against the Positive Behaviour Support Capability Framework as safeguard against unapproved approaches being applied, providing a pathway for recognition and professional progression for practitioners.

Accredited behaviour support practitioners are funded to develop a PBS plan for an NDIS participant with complex behaviours under the capacity building budget: “improved relationships.” The NDIS RPBS Rules set out the conditions that apply to all registered NDIS service providers, describing the restrictive practices that are regulated and what should be included in behaviour support services, as well as:

- outlining reporting and oversight arrangements to reduce and eliminate the use of restrictive practices;
- the registration of providers delivering specialist behaviour support and providers who use restrictive practices in the course of delivering funded services;
- requiring that providers comply with any state and territory authorisation arrangements in relation to the use of restrictive practices.

This Positive Behaviour Support Capability Framework explains the knowledge and skills required by a behaviour support practitioner in each of the following domains, against which are the policies, programs and procedures that implementing service providers require to ensure best practice. The capability framework also provides a conceptual framework for the NDIS Commissions’ monitoring and

evaluation approach on quality of plans and implementation outcomes. The domains of the PBS Capability Framework are shown below:

Figure 1



Since the commencement of the NDIS Commission in Queensland in July 2019, NDIS registered specialist support providers have changed processes. Previously, once the PBS plan was authorised, the service provider could use the restrictive practices. Now, the registered service provider must submit the individual's PBS plan to the NDIS Commission, indicating whether these have been duly authorised by the relevant state. Implementing providers then activate plans and then report monthly on the use of restrictive practices for the duration of the plan.

The scope an application of the NDIS RPBS Rules differs from that specified by Queensland regulation:

- *what*, the NDIS articulates five categories of restrictive practices: seclusion, chemical restraint, mechanical restraint, physical restraint and environmental restraint which includes LGDW;
- *where* is inclusive of all sites in which registered providers deliver NDIS funded services; and
- *who* encompasses all NDIS participants.

Legislative comparison

One of the notable and innovative features of the UNCRPD is the regulatory regime it establishes: regulatory functions are delegated to a wide range of actors, including civil society actors, which is thought to diminish the possibility of regulatory capture (Arduin 2019). For the purposes of this review,

it is important to distinguish what constitutes efficacious regulation as the methodology of implementation and process for authorisation can differ substantially between:

- the *focus* and *target* of regulation—it is possible to distinguish between regulations that target specific practices, the authorising environments for specific practices and the outcomes of interventions or performance of systems (May 2007)
- the *prescriptiveness* of regulation—which can be more or less, allowing greater discretion in interpretation and/or responsiveness in implementation
- the *methodology* for implementing regulation, or the means through which adherence is obtained, compliance may be motivated by compulsion (sanctions) or through negotiation or persuasion, or by building capability
- the *authorising environment* for regulation—there is a continuum from state-based to self-regulation with forms of meta-regulation, co-regulation and enforced self-regulation in between (Schweppenstedde et al. 2014).

Across these different dimensions, there is significant variation across Australian jurisdictions with respect to the regulatory frameworks which authorise the use of restrictive practices. The two tables below summarise the authorising environment for the ACT and Victoria respectively. Both jurisdictions provide for the appointment of a senior practitioner with significant responsibilities, although other agencies also have a continuing role in the broader regulatory framework.

In the ACT, the Senior Practitioner has purview of disability services as well as those that provide education, care and protection for children. The key distinction between the two models, however, is that in the ACT the Senior Practitioner is empowered to develop guidelines and disseminate information, to undertake research and construct networks, to receive complaints and conduct investigations, but not to directly authorise the use of restrictive practices. The actual authorisation for the use of a restrictive practice is the responsibility of a Positive Behaviour Support Panel, which is independent of the provider. The *Senior Practitioner Act 2018* (ACT) provides that the Senior Practitioner will issue guidelines about the composition of such panels: this is an example of meta-regulation. As an interim step a central panel was established in the ACT. In Victoria, however, the Senior Practitioner is directly responsible for the authorisation of PBS plans that involve seclusion, mechanical, physical or chemical restraint.

The analysis summarised in the table below also indicates some key departures from the structure of regulation in Queensland. In particular, while the role of appointed guardians is registered in both frameworks, unlike in Queensland guardians are not empowered to consent to the use of restrictive practices in any circumstances. In all instances, authorisation is vested in a third agency – either the Senior Practitioner or VCAT in Victoria or the Positive Behaviour Support Panel in the ACT. The distinctions between the two systems also demonstrate the distinction between meta-regulation that focuses on process and governance, and direct regulation that assumes responsibility for authorisation. Thus, in Queensland, the Disability Services authorise emergency restrictive practice usage only. The OPG do all other authorisations currently together with QCAT for containment and seclusion. Disability Services have guidelines and policies for the Short Term Approval process only; but do not conduct investigations or resolve restrictive practices complaints which typically would be referred to the NDIS Commission. The Disability Services do not undertake research in relation to restrictive practices but undertakes education in relate to state based authorisation frameworks. Note that Disability Services is responsible for AS&RS until it transitions in June 2023 and therefore writes PBS plans for the clients of AS&RS.

Table 5 (ACT in blue, Victoria in purple, NDIS functions in green)

Australian Capital Territory	Relevant legislation: Public Trustee and Guardianship Act 1985; Disability Services Act 1991; Human Rights Act 2004; Official Visitor Act 2012; Human Rights Commission Act 2015; Senior Practitioner Act 2018						
Victoria	Relevant legislation: Disability Act 2006; Victorian Civil and Administrative Act 1998; Guardianship and Administration Act 2019						
NDIS	NDIS Act 2013; NDIS RPBS Rules						
Relevant body: Authorized to ...	the use of restrictive practices	issue guidelines or directives	conduct investigations and/or resolve complaints	Appoint guardians	undertake guardianship responsibilities	register behaviour support plans	undertake research and education
Senior Practitioner *	 ¹	 	 			 	  
Community/ Official Visitor			 				
Civil and Administrative Tribunal	²			 			
Public Advocate/ Public Trustee/ Public Guardian					 		
Positive Behaviour Support Panels							
Authorized Program Officer	 ³						
Disability Services Commissioner/CEO							

NDIS Quality and Safety Commissio n		✓	✓				
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For Victoria: 1. for seclusion, mechanical, physical, chemical restraint 2. supervised treatment order 3. Within PS PLANS

*in Queensland, the Executive Director, Positive Behaviour Support and Restrictive Practices Team, Disability Servies effectively takes this role as delegate of CEO, Disability Services

Consultation findings

The consultations involved wide-ranging discussions about the regulatory frameworks operative in Queensland and the operation of Queensland's regulation in light of the commencement of the NDIS Commission. The discussion below reports the feedback obtained from the consultations, which means that some of the observations fall outside the terms of reference for the review. Nonetheless, such observations are relevant to the broader policy context and provide further context for the options discussed in the following chapter.

It has not been possible to triangulate the findings in the time available with data or additional sources of evidence. As is always the case when talking to participants whose sense of professional expertise and integrity is attached to the issues under discussion, some caution in interpretation is warranted in the absence of a further evidence base through which to filter the perspectives.

Additionally, levels of frustration were expressed: however, it was not possible to ascertain whether these were a consequence of long held grievances and concerns, or whether these pertained to the period following the commencement of the NDIS Commission in Queensland. Indeed, at the conclusion of more than one focus group, participants realised that while they had ventilated much critique, the Queensland system had strengths, in particular the intent of the regulatory framework. While many participants indicated an appetite for change and reform, many were concerned about the loss of protections too.

The current regulatory environment

There was a clear understanding that advancing the human rights of people with a disability is the core purpose of the regulatory framework and this commitment was shared by all stakeholders. Most seemed to accept the centrality of guardianship to the operation of Queensland's regulations (though there is a broader debate about whether substitute decision-making is consistent with the UNCRPD). There was also some divergence of opinion:

- For some the processes of safeguarding human rights under extant regulatory frameworks erred on the side of paternalism, the level of scrutiny, the amount of reporting and the length of time it takes to secure authorisation means that practitioners and providers are dissuaded from taking risks, or allowing people with a disability to take risks, that might enhance independence.
- For others the emphasis on human rights problematically eclipsed the importance of the duty of care owed to people with a disability. Participants reported there is a failure to understand that some forms of restrictive practice can have a pedagogical effect. If used carefully in the context of a PBS approach that was developmentally appropriate, they could advance the wellbeing of person concerned.
- Others suggested that the concept of harm was too narrowly conceived by the regulations, with undue emphasis on physical harm when often that harms about which providers and practitioners were concerned with related to chronic health issues, such as diabetes, which could be exasperated over time through forms of consumption, although a single instance/occasion may not cause harm directly. Interviewees thought the regulatory framework should provide for greater latitude in interpreting what led to harm and thereby provide discretion in the design of PBS plans.

- A few raised the question of whether the regulations balance the rights to safety and wellbeing of carers and workers who may be exposed to harm in the absence of certain restrictive practices. Some participants indicated that this conversation was very difficult to have and worried the debate was hamstrung by ideological convictions rather than pragmatic considerations.
- Some were concerned that lack of consistency between the Queensland legislation and NDIS RPBS Rules undermined the message about human rights. The core concerns were that either confusion about which principles (state or national) to apply in what circumstances, and whether reluctance to incorporate the National Rules into clinical governance and practice would impede understanding the link between regulations and rights.
- Others suggested that limitations in Queensland's regulations had been exposed by the commencement of National Rules (with the National Rules' broader scope and application to more people with a disability) and undermines the claim often made by Queensland Government that it safeguards rights by making visible the limited extent of restrictive practices.

There was also some confusion about whether and how the new QHRA was relevant to work in the space of positive behaviour support and the regulation of restrictive practices. Some were aware of the additional complaints' mechanisms which people with a disability could access, and others not identifying any relevance to their work.

Regulation purposiveness

Among participants, there was a clear understanding that the purpose of the regulatory framework is to eliminate the use of restrictive practices, or where these have been authorised, to ensure that the least restrictive alternative is selected and implemented in the context of multi-disciplinary plan that prioritises the wellbeing of the individuals concerned. Participants were fully committed to the realisation of this purpose. Many were concerned, though, that new providers and the Disability Services workforce were not prepared to manage the use of restrictive practices nor skilled enough to implement PBS plans. This new workforce may not be fully committed realising the purposes of the regulations, in part because the framework is poorly understood by them.

There was some divergence of opinion as to whether the current regulatory framework advanced the purposes articulated by legislation:

- For those who had worked within the Queensland regulatory framework for some time, and who indicated familiarity with the authorisation processes, its capacity to safeguard rights and limit the use of restrictive practices was well understood.
- Others experienced the Queensland system as excessively process focused at the expense of the quality of the behavioural interventions proposed. Participants shared a number of anecdotes that demonstrated this trend, although it was not clear whether these examples were representative of the way the system operates or simply memorable outliers. These participants found the processes complex and confusing, and even more so for those encountering the system for the first time, thus interfering with the purpose of eliminating restrictive practices.

Participants also articulated some concern that the transition to the NDIS had interfered with the purposiveness of the system. Whatever clarity there may have been about the process of authorisation, had been somewhat muddled by the introduction of new reporting requirements. In particular, it was

perceived that the regulatory agencies in Queensland had reduced capacity to monitor and enforce the extant regulatory framework. These functions are important given the purpose of Queensland's framework is to ensure that use of restrictive practices is limited and eliminated.

It was not clear to what extent this reservation reflected the particular point we are at in transition. Participants are clearly creating new systems (e.g. clinical governance) and practices (e.g. risk management) and adapting existing tools (e.g. PBS plans) in response to the new NDIS requirements. This may be more likely in larger organisations with more experience with the regulatory framework and where there are sufficient resources to invest in the design of administrative and operating systems that support continuous quality improvements. It is clear that some agencies have more capability in this regard.

Regulation is proportionate

Different actors within the system emphasised different aspects of proportionality. The weight of scrutiny and review proceeding authorisation was felt:

- For many the level of emphasis given to the regulation of seclusion and containment was proportional to the potential for harm entailed in this practice, although some would prefer that there were stronger disincentives in legislation to use these practices. Some practitioners were insistent that any reduction to the regulation of these practices would be a significant and retrograde step in the pursuit of human rights for people with a disability. Others suggested that in light of evidence that physical and mechanical restraints could cause significant harm to an individual, these should also be subject to more intensive review.
- Some suggested that extant regulatory framework did not place enough scrutiny on the use of chemical restraint particularly given that the National Rules encompass individuals with autism and dual diagnoses including mental illness.
- There were various perspectives on whether Queensland regulations on LGDW were appropriate. For the most part participants preferred the Queensland approach that allows service providers to act with discretion where an individual has a skills deficit and is at risk of physical harm if allowed unsupervised freedom of movement.

The issue of proportionality was also raised in another sense. Both clinical practitioners and providers suggested that the weight of regulation on *authorisation* was disproportional to any emphasis on *implementation*. The consequence is the regulatory system cannot be confident that authorised practices are implemented in the least restrictive way nor whether the PBS plans reduce the use of such practices and promote positive outcomes for the individuals concerned.

A few participants raised whether Queensland's regulations placed sufficient emphasis on the active participation of the individual subject of restrictive practices and positive behaviour support. Indeed, there seemed to be some lexical confusion about the term consent, with this being conflated with consultation.

Finally, participants were uncertain about whether the centrality of guardianship in Queensland's regulatory framework could withstand the inclusion of adults without cognitive impairments. Queensland's framework has been designed to safeguard the rights of people who find it difficult to self-advocate and have their perspectives appreciated. This presumption helps explain where the emphasis is placed in the current authorisation process.

There were some clear differences of opinion about whether the system currently provides for accountability, transparency and accessibility:

- A number of participants were concerned that accountability of providers had been diminished since the application of the National Rules, because Queensland no longer has this responsibility it was thought to create risks because the monitoring body may not share the exact purposes, rationale and motivations of the authorising body, creating some (potential) discordance between authorisation and safeguarding. There was divergent opinion about whether the NDIS Commission had efficaciously assumed this responsibility, with some participants having received helpful feedback and others not.
- There was some indication that while providers were accountable for the implementation of the plans, the regulatory framework does not hold anyone accountable for the quality of the planning process. That is, whether or not the assessments were sufficiently comprehensive, consultative and collaborative and whether the strategies identified were consistent with the best available evidence.
- None of the participants had a clear understanding of whether Queensland's regulatory framework has been accountable to its overarching objectives. There seems to be low awareness of any statistical trends in the use of restrictive practices, whether these have diminished since its creation. Participants recognised that evaluation is difficult in the absence of data, counterfactual conditions and comparator groups.
- This issue of transparency pertaining to both the process itself and the decisions made was discussed. The processes are well understood by those with historical experience but less so by more recent entrants into the market with implications for whether the framework is considered transparent. Participants also indicated that transparency was troubled by inconsistent advice from representatives of the Queensland Government, who were in some instances reluctant to provide clear advice and interpretations. It was acknowledged, however, that both these issues were possibly a result of staff cuts and ongoing negotiations about the division of labour between Queensland Government and the NDIS.
- In addition to navigating the process of applying for authorisation, there was some concern that the decision-making processes were not fully transparent either, particularly when decisions are made on a review of the papers. Even when hearings are convened, the inquisitorial and adversarial nature of these, coupled with the location of hearings, limits the transparency of the process to those without legal training.
- Transparency was also limited in the review processes, recognised in the absence of a straightforward mechanism with which to appeal decisions and challenge an authorisation during the approved period or complain about implementation of a restrictive practice.

Challenges to a culture of collaboration in the implementation of the regulations was identified:

- Some participants perceived the division of decision-making responsibility between the multiple agents as “silo-ing” and an impediment to collaboration in achieving the aims of the legislation.
- There was some concern that the authorisation processes had not been amended following the NDIS transition and the outsourcing of clinical support for functional assessments and the development of behaviour support plans. The original process had been designed when this function was undertaken in-house. The OPG was mentioned a few times in this regard as being unwilling to engage directly with clinical practitioners as the service agreement was with the implementing provider.
- Participants indicated the commencement of the NDIS, and subsequently the National Rules, had resulted in a considerable expansion in the number of stakeholders required to collaborate with to have an efficacious response to complex behaviours. In particular, many participants noted the need to systematically address complex behaviour was often missed by LACs during the NDIS planning process and that support co-ordinators had low levels of appreciation for the significance of this work. For those who required funding to undertake the relevant assessments and develop a behaviour support plan in order to authorise the use of restrictive practice, it could mean initiating a NDIS plan review to obtain additional funding prior to undertaking an assessment, with implications for the timeliness of an effective response, resulting in an extension of the time during which unauthorised practices might be used.
- Additionally, participants reported that support coordinators, concerned with ensuring participants could exercise choice and control, or change the clinician contracted to undertake the work. From the perspective of implementing providers this could disrupt relationships and further exacerbate delays in obtaining and authorising efficacious behaviour support plans. Where these changes had catalysed more strategic governance adaptations by providers, these same processes were thought to enhance collaboration. This, however, was a minority view.

Regulation prioritises practice reform

According to those who had historical experience of the system, when the legislative framework was first enacted there was a clear emphasis on practice reform. These same participants suggested that this emphasis had diminished over-time. There was an emergent opinion by some participants that the national reporting requirements of each single unauthorised practice including LGDW, could impede ongoing practice reform and quality improvements. A number of observations lend weight to this observation:

- Many participants noted that analysing and responding to complex behaviours to promote the rights, dignity and wellbeing of people with a disability and their carers (including paid staff) requires an iterative approach. But the procedural focus is on reporting single incidents, often before a pattern has been established and/or understood. Participants identified this focus as promoting reactivity. This has implications for compliance with reporting requirements because their staff’s use of singular instances of restrictive practices in highly specific circumstances may lead to reprimand and or sanction rather than investment in staff capability to manage these circumstances more effectively.
- Participants agreed that when such instances occur, success can be measured by the speed with which an alternative procedure can be agreed and implemented. This does not always

require a full process of assessment and planning, but the regulatory framework seems to demand this response. In turn, this can detract from the use of simple and innovative solutions at the expense of local knowledge.

- Participants also identified that once the process to obtain an authorisation is completed, there is little incentive to retract the behaviour support plan. Even if the plan has been effective in reducing the regularity with which a restrictive practice is used, any risk that it may be required in the future means extensions are applied for to avoid having to recommence the process.

These observations are not applicable to all circumstances or all forms of restrictive practice. But participants noted that the enlarged definition of restrictive practices employed by the NDIS increases the probability of a formalised clinical response. Moreover, the authorisation processes in Queensland made the development of iterative and flexible plans difficult.

Some participants articulated a concern that the introduction of the National Rules had entrenched positive behaviour support as the only modality through which complex behaviours might be addressed. Alternative approaches nominated included trauma-informed approaches, and skills development. Participants were not clear that these approaches could not be incorporated under the auspice of positive behaviour while some participants were clear that a diversification in approaches was required, particularly as more people at different life stages entered the system.

Regulation predisposes parties to comply

There were mixed views on whether the regulatory framework currently promotes compliance. The changing role of the Queensland Government to monitor implementation and manage complaints was submitted as a reason why it might not be the case. For some it was not entirely clear who was monitoring compliance.

But of greater concern to many participants was whether recent entrants to the market had a sufficient understanding of restrictive practices, their implications for people with a disability, and thus the rationale to limit their use. In other words, compliance could be inhibited not because of the structure of the regulatory system or the division of labour between Queensland and the NDIS, but because providers do not have the capability to comply. This view was strongly put by clinical practitioners who found themselves not only developing PBS plans but also training new providers to implement plans. These providers often had little understanding about the regulations and their purpose. It was difficult to ascertain how widespread this problem is, but partisans of this perspective were vociferous on this issue.

Regulation is supported by resources for implementation

The question of resourcing was consistently raised by participants as to whether:

- NDIS Commission had sufficient resources to effectively monitor the use of restrictive practices and ensure the quality of behaviour support plans
- Disability Services had sufficient staff to continue to provide clinical guidance to the sector
- QCAT Registry had sufficient resources to provide Members with case management support.

- the Community Visitors' program was equipped to identify and advocate for improved conditions for people with a disability in receipt of accommodation support
- NDIS plans were structured to incorporate the right level of support to address complex behaviours, and
- NDIS pricing guide contained the right level of funding for the development and implementation PBS plans of varying complexity.

Discussion

Participants considered this Review a harbinger of change, largely welcomed this possibility and were grateful for the opportunity to participate with this early stage of that process.

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability examined the issue of restrictive practices, in particular the use of psychotropic medication to address behaviours of concern, beginning on 22 September 2020.

The views expressed by the Counsel Assisting echoed what is already known by the research fraternity, advocates, clinicians and those working in the authorising frameworks and validated in this Review:

- there is an absence of nationally consistent laws and regulations of the use of psychotropic medication for people with disability or autism.
- restraints of any type impair a person's human rights, a person's freedom of movement, liberty, privacy and the right not to be subjected to cruel, inhuman or degrading treatment as well as the right to the enjoyment of the highest attainable standard of health without discrimination.
- there is a distinction between medication used to restrain a person and medication used to appropriately treat an illness or disorder but it is not always clear in prescribing process. This is for a number of reasons including:
 1. there rarely interaction between a medical practitioner and a behaviour support practitioner to consider or develop alternatives to chemical restraint and
 2. there are vested interests at play to seeking simple solution of a chemical restraint rather than opting for a more intensive approach of capacity building.
- the criticality of relevant clinical expertise that is required for the authorising function, that decisions should be to be clinically driven, and this should be embedded into the authorising agency. The Public Guardian was heavily questioned about the lack of clinical expertise in the team responsible for authorisation and reviews should be more than an administrative review.
- PBS and capacity skills building are an effective alternative to restrictive practices. Comprehensive collaborative multi-disciplinary assessments of an individual must occur to understand the determinants of behaviour and develop a person-centred model of care.
- the adequate training for support workers and use of casual staff exacerbates the poor implementation of behavioural support programs.

- restrictive interventions are defined differently across jurisdictions drives poor and inconsistent data.
- limited, and in many cases, the absence of, data to evaluate PBS plans and their implementation at an individual level, and, at a strategic level, drive the elimination of restrictive practices.

Proposed changes

The current state of the regulation of restrictive practices in Queensland was analysed from the literature review, the legislative comparison work and from the results of the consultations. All participants in the consultations shared the Queensland Government's conviction that the regulatory framework should advance human rights and involves working towards the elimination of the use of restrictive practices. Where this was not possible, ensuring that the use of such practices resulted in the least possible diminution of rights. Participants and the literature agreed that the PBS plan should ultimately advance the developmental goals and wellbeing of the person involved. All stakeholders considered that they were working towards this shared goal, but all encountered some impediments to actually progressing it.

These concerns related to structures and processes, but also cultures and practices. The regulatory framework was found to be not well-balanced (proportionate) across the range of restrictive practices. With respect to processes of applying for authorisation, the regulations were seen as complicated and difficult to navigate. Some of the concerns relating to transparency, accountability and accessibility have been exacerbated by the transition to the NDIS, which has resulted in new processes as well as new entrants to the service provision market and an expansion in the numbers of people in receipt of disability support.

The lack of consistency between definitions and the scope of regulation between the National Rules and Queensland's framework caused concern. Of particular concern was LGDW. LGDW can be envisaged as containment, and lead to seclusion, if not managed / implemented correctly. In Queensland, the use of LGDW relates to whether the person has a "skills deficit". In addition, there is no oversight / regulation of LGDW in current system and no imperative for a provider to try and develop the skills of the person with the disability via a PBS Plan (as no plan is required). It is advised that consultation occurs with people with disabilities about the discretion that is available to providers, and whether this is appropriate.

These circumstances, however, provide a clear opportunity for change. In the consultations many stakeholders were anticipating further change to Queensland's regulations and have given consideration to what these might entail. Some of the specific changes identified from the consultation and the literature review are detailed below:

Table 6

<p>For people subject to restrictive practices: The National Rules are more expansive in their application to all people in receipt of disability support regardless of age, impairment or diagnosis, and in line with human rights, an expansion of the authorisation process in Queensland is warranted.</p> <p>In Queensland there is no authorising framework for the use of restrictive practices with children with a disability (including those in the OOHC system).</p> <p>An overarching approach across sectors and cohorts of affected persons (including mental health and aged care services) to eliminate the use of restrictive practices could complement Queensland's broader commitment to advance human rights.</p>
<p>Definitions of restrictive practices: There was a strong sense that Queensland's regulation is proportionate as it applies to containment and seclusion. However, LGDW are defined as restrictive practices in all circumstances in the National Rules and could be translated into Queensland.</p>
<p>Implementation locations: The Queensland authorisation framework applies to all funded NDIS participants.</p> <p>To achieve the ultimate aims of the NDIS of increased social and economic participation, the authorisation process needs to encompass or contemplate the application of both PBS and restrictive practices in additional locations, such as workplaces and health care settings.</p>
<p>To improve accountability, transparency and accessibility:</p> <ul style="list-style-type: none">• Remove undue complexity by consolidating and streamlining decision-making processes• Ensure greater accountability by expanding the use of panels of decision-makers, that include advocates, and oral hearings• Develop pathways for more active participation and consent by people with a disability in the process of decision-making• Simplify the paperwork to enable the development of more iterative plans with greater flexibility in implementation• Give consideration to appeals processes and more accessible complaints processes.• Clarification for service providers to confirm there is no requirement for duplicative reporting and lines of reporting is required: the state's role is authorisation, while NDIS is responsible for the care of people with a disability. Hence reporting on numbers of clients subject to PBS and restrictive practices should only be to NDIS Commission (as with reportable incidents) for monitoring, trend analysis and evaluation.
<p>Practice reform: The consultation revealed that providers and clinical practitioners were engaged in communities of practice, developing micro-credentials and other training packages, as well as clinical governance and risk management systems, all to build the capability of the sector to respond to clients with complex behaviour and reduce the use of restrictive practices.</p> <p>There is a need for an active role in stewarding practice development. This means more than clinical advice and includes more extensive, comprehensive and consistent training and professional development for clinicians and care workers. A facet of this is recognising that PBS plan development needs to incorporate the skill level of the workers implementing the plan. These are components of the capacity development of the sector (an NDIS Commission jurisdiction).</p>
<p>Compliance could be enhanced by:</p> <ul style="list-style-type: none">• Achieving greater consistency between Queensland regulation and the National Rules• By building the capability of new market entrants and the confidence of the sector that a consistent approach would be taken to monitoring and evaluation

- Attaining clarity about the specific roles of Disability Services, QHRC, the OPA and the NDIS Commission in monitoring both the quality of plans and their effective implementation.

Resourcing:

Changes to the level at which the NDIA funds functional assessments and the development and implementation of PBS plans would improve client outcomes. However, there are resource (and in some cases, expertise) constraints under which the DISABILITY SERVICES, OPG and QCAT currently operate which impact the timeliness of decision-making and PBS plan development.

Implications achieve greater consistency

The draft principles for national consistent restrictive practices' authorisation processes were not shared with participants in the consultation as the draft principles had not been publicly released by the NDIS Commission at the time the consultation arrangements were finalised.

For this reason, assessing the kinds of reforms that would be acceptable to stakeholders and designing these reforms through a co-design process was not possible. However, some clear themes were apparent, including the following:

- preference for a nationally consistent framework, with shared scope and definitions
- preference for a streamlined authorisation process, with greater flexibility and opportunity to iterate and modify strategies in implementation
- preference for greater transparency and accountability in the operation of the regulations
- support for increasing the accessibility of the process of authorisation and the operation of the regulations more broadly for people with a disability
- appetite for greater information about the efficacy of regulations at a population level and the impact of PBS at an individual level and implementation at an organisational level
- appetite for a renewed campaign to sponsor practice reform and build the capability of new entrants into the NDIS, both participants and providers
- expectation of greater resourcing to ensure the system operates in the best interest of all stakeholders, so that agencies can acquit their statutory obligations and practitioners/providers can advance the rights and wellbeing of people with a disability

With these themes in mind, the changes proposed by the consultation participants and findings from the literature review and legislation comparison, the following table provides commentary against each of the draft national principles:

Table 7

<p>Principle 1 Authorisation arrangements for the use of restrictive practices on people with a disability are provided for in legislation and support the reduction and elimination of restrictive practices as agreed by all Australian Governments</p>
<p>Queensland's legislative base would need to be updated to expand scope to adults and children with all disability types. The Review notes that this is a broader group than just those who are NDIS participants; however the inclusion of this broader group addresses the requirements of the QHRA.</p>
<p>Principle 2 Authorisation arrangements, and the systems surrounding them, should be designed to support positive outcomes for people with a disability who are subject to restrictive practices with the objective of reducing and ultimately eliminating those practices</p>
<p>Consultation participants indicated support for this principle. Participants and the literature reinforces that the process of undertaking a functional assessment to understand the factors which trigger complex behaviours of concern is important. It is the first step in designing strategies to address these and simultaneously limiting the use of restrictive practices. A more iterative process supporting adaptive interventions could also advance outcomes for people with a disability.</p> <p>The process of authorisation is unlikely in of itself to reduce/eliminate the use of restrictive practices, excepting where these are clearly prohibited with enforceable sanctions. The risk and protective factors need to be addressed in the broader Disability Services system to advance the elimination of restrictive practices. To achieve this, there is a need for further training and action research, alongside accessible metrics and evaluations to identify alternative strategies with which to avoid and meliorate the complex behaviours of concern.</p>
<p>Principle 3 People with a disability who are subject to restrictive practices have the same protections and rights to be free from abuse, neglect and exploitation regardless of their disability, age and where they live</p>
<p>To be in alignment with this principle Queensland legislation would need reform to provide an authorisation process for the use of restrictive practices on all people with a disability, irrespective of their age or where they live.</p> <p>The project team's analysis of the QHRA also supports this principle.</p>
<p>Principle 4 People with a disability and their support networks are actively supported in the decision-making process about the use of restrictive practices, and alternative practices that may improve outcomes for the person with disability through the reduction of their use</p>
<p>The current authorisation process could do more to support active participation: expert needs assessment does not replace empathetically ascertaining preferences directly with the person concerned.</p>
<p>Principle 5 Authorisation decisions made under state and territory regulatory frameworks are informed by independent advice from experts with relevant training, skills and experience in positive behaviour support and restrictive practices</p>
<p>In Queensland, experts with the relevant and training in skills are involved in the development of PBS plans. The clinical practitioners consulted had some reservations about the skills of some providers and their staff to manage and implement PBS plans, particularly new market entrants.</p> <p>With respect to the authorisation process there were two additional reservations that should be addressed:</p>

- Decisions can be made by a single QCAT Member on the papers without oral hearings which would allow for discussion with relevant experts, as well the individual subject to PBS plan.⁵
- Not all appointed guardians are well versed in either PBS or human rights approaches, which could compromise their capacity to justify the use of restrictive practices and to identify and advocate for alternatives.

Principle 6 Authorisation frameworks should ensure that any conflicts of interest between key parties in decision-making on the use of restrictive practices, being people with disability, their support networks and service providers are effectively mitigated

Collaboration between the person with a disability, clinical practitioners, implementing providers and authorising agencies was acknowledged as important to the success of PBS plans. With the introduction of NDIS in Queensland, this network of collaborators now needs to extend to LACs and in some instances, support co-ordinators.

The Review identifies guardians and carers as having some conflict of interest when addressing complex behaviours as a restrictive practice might seem a simpler, faster solution (for example, chemical restraint) or where the guardian's desired outcome outweighs the individual's wishes (for example in chemical libido reduction, access to partners). Time constraints in decision making are also conducive to conflicts of interest between key parties in decision-making. These aspects have been incorporated in design of the options proposed.

Principle 7 Authorisation arrangements promote independence and dignity of risk while also considering the interests and protections of rights of the person with a disability

Some participants suggested that existing safeguards were proportionate and thereby allowed for a balance between rights and risks. Others were less convinced. Case studies shared during the focus groups and the literature review highlighted that there is a clear understanding that intervention, including restrictive practices, may be required to deal with imminent harm. But the many and varied circumstances in which behaviours of concern might become evident must be balanced with the dignity of risk. Some participants, and lessons from the aged care sector, indicated choice as the antidote to restriction, coupled with open communication with all parties. It is clear that nuanced and careful judgements are required; however, there was no clarity in process that indicated how the authorisation process supports such judgements.

Principle 8 Decisions made on the use of restrictive practices are able to be reviewed if required through relevant state of territory mechanisms

The centrality of guardianship to the authorisation process in Queensland, excepting in the case of seclusion and containment, effectively side-lines the question of review, because the guardian is considered to have consented to the use of restrictive practices on behalf of the individual concerned. There are, however, relevant observations:

- There were some reservations about whether appointed guardians were best able to ascertain the quality of PBS plans containing restrictive practices. But this suggested the importance of independently assessing plan quality, not necessarily review by an alternative agency.
- PBS plans should be considered to be live documents, and the strategies they entail iterative, so there is a built-in feature for the regular review of the efficacy of the PBS plan.

⁵ The project team notes that there are limited circumstances where a decision by QCAT can be made on the papers. A review on the papers only takes place in relation to a previous approval – if any party/person requests an oral hearing, QCAT accommodates that request (with sometimes a short-term OTP approval to ensure approvals remain in place pending the arrangement of an oral hearing).

- The community visitor scheme should not be considered a review mechanism: they neither have the relevant training and expertise to understand the PBS approaches and assess the use of restrictive practices accordingly.

Principle 9 Authorisation arrangements are streamlined and take into account the impact of the administrative burden on providers

Streamlined processes should always be the goal. The project team's conversations with advocates and those with direct experience of the authorisation processes in other jurisdictions, indicated having one authorising agency with one oversight agency for review and complaints would be preferable.

Principle 10 Commonwealth and state and territory governments will continue to work together to apply these principles in practice, using NDIS governance arrangements to monitor progress in achieving national consistency

Based on the consultation, the project team recommends progress towards greater consistency. Further consultation with people with a disability should highlight the benefits of greater consistency, given the people with a disability should be able to travel and visit other Australian jurisdictions without having to navigate other systems.

Options for regulatory reform in Queensland

The terms of reference for this Independent Review indicate that the analysis should give specific consideration to:

- The current functions of the Chief Executive of Disability Services (or delegate) as outlined by the *Disability Services Act 2006* to develop a positive behaviour support plan for containment or seclusion or an associated practice, and to provide short-term approval for the use of a restrictive practices other than containment of seclusion
- The impact of including environmental restraint, as defined by the NDIS RPPB Rules, as a type of restrictive practice in Queensland legislation which would require specifying an authorisation process for the use of such restraints, including LGDW
- The impact of the extension, or modification, of the current regulatory framework to include cohorts of NDIS participants without an intellectual or cognitive disability, including children
- Whether there should be alteration to existing immunity provisions and/or further specification of restrictive practices that are prohibited, the use of which would attract enforceable sanctions.

Although these Terms of Reference pertain to quite specific aspects of the operative regulatory framework, the Review has taken a wholistic approach to the broader system, consistent with the literature on efficacious regulation and the perspectives shared during the consultations. There will be NDIS participants who may cross several Queensland government portfolios and experience an unregulated restrictive practice – a child in juvenile detention who has both intellectual disability and mental health issues, for example.

On the basis of the research conducted, and to ensure Queensland's future position aligns with the QHRA and the expected outcomes of the Disability Royal Commission, the Review has developed three options for reform. These address the four issues above as well as the ambition to eliminate restrictive practices and advance the human rights of people with a disability. Option 1 retains the existing

safeguards and guardianship approach of the current authorisation framework while expanding the scope to include adults and children with all forms of disability. Option 2 involves a re-organisation of the authorising system, moving away from the guardianship model and providing a consistent authorisation process for all adults and children irrespective of whether they have an intellectual disability or not. Option 3 redesigns the authorisation system to have one agency responsible and a higher level available for reviews and appeals.

For all three options: the Review recommends:

- Queensland legislation be amended to extend the application of the authorisation process to all persons with a disability regardless of age, noting this is broader than NDIS participants to meet the requirements of the QHRA and its mantle of protection for all people.
- Maintaining the independence of authorisation for the use of restrictive practices from the service provider
- Ensuring that the definition of restrictive practices is aligned with the NDIS (RPBS) Rules by Queensland's legislative framework should adopt the broader Commonwealth definition of environmental restraint which includes "containment" and "restricted access to objects", and clarifying that LGDWs would fall into this category (ie LGDWs would no longer be deemed not to be a restrictive practices under Queensland framework).
- Embedding the interim/emergency authorisation system independent of the service provider and alerts about any emergency authorisations that are extended past 12 months for all forms of restrictive practices
- Explicitly prohibit certain practices. As a minimum this list should include all the forms of physical restraint as prohibited by the Victorian Senior Practitioner: prone restraint, supine restraint, pin downs, take down techniques and any technique that interferes with respiration or digestion, pushed a person's head towards their chest and physical restraints that inflict pain and hyperextension of joints or pressure on joints or chest. In addition, include the prohibitions contained in the NSW Restrictive Practices Authorisation Policy (v2.0), which includes aversion, over-correction, misuse of medication and denial of key needs.
- Clarifying with the Disability Services sector the separation of the authorisation process (state responsibility) from the monitoring/ capability building/ evaluation role (NDIS Commission responsibility).
- To increase systemic accountability, the Chief Executive of Disability Services reports on trends in the authorisation of restrictive practices in the departmental annual report. Of particular interest is any trends relating to where authorisation might continue but in a reduced application, enabling a measure progress towards elimination of use.

For all options, to complement the active participation of the individual with a disability, it submitted that legal or advocacy representation for vulnerable people in QCAT should be fully funded for guardianship orders, as well as funding for legal or other representation for significant administrative reviews. Support should include but not be limited to legal representation, where other forms of representation may already be available or be more appropriate e.g. through community legal centres or advocates or through the adult's support network. The important role of other representatives currently permitted to advocate on behalf of the person with impaired capacity in QCAT proceedings

may lead to delays in hearings, however, the seriousness of the human rights outcomes in restrictive practices cases means the affected person should have representation.

Stakeholders confirmed concerns about taking a stepped change approach to moving the authorisation program in that it introduces risks of incomplete changes creating more confusion for the Disability Services sector.

Option 1: Maintaining the guardianship model

This option:

- maintains the current authorisation processes for adults with an intellectual disability or a cognitive impairment
- however, rather than rely on a guardian for restrictive practices for individuals (adults and children) whose disability is not intellectual and does not impair cognitive functioning, the authorisation must rely on consent of that individual, and that consent should be express and witnessed.⁶
- The DSA will also need to be altered to ensure consultation with the child protection system for children in this system, as is currently the case for adults subject to a forensic order, treatment order, or treatment authority.

Option 2: Moving away from guardianship

The second option takes a step towards a streamlined process for authorisation, with implications for the roles of other public agencies involved in the broader regulatory system, including the Public Guardian, the Public Advocate and the Human Rights Commission.

In developing this option, the project team considered the regulatory frameworks operating in Victoria and the ACT. In both cases there is:

- a statutory foundation for the authorisation of restrictive practices
- a number of public agencies involved in the broader framework.
- An Authorised Officer with clinical expertise (in Victoria this is called the Senior Practitioner) with some overlapping responsibilities.

In Victoria, the Senior Practitioner authorises the use of seclusion, mechanical, or physical restraint. In the ACT, the regulatory function of the Senior Practitioner is directed towards issuing guidelines and directives and conducting investigations and resolving complaints, while the PBS Panels, constituted independently of providers, undertake authorisation. There is no clear evidence that either of the above models advances the rights of people with a disability more or more effectively eliminates the use of restrictive practices. However, the advantage of both models over the framework operating in Queensland, is that the process involves experienced clinicians who can interrogate PBS plans and

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does not rely on appointed guardians who may or may not be able to gauge the quality of PBS plans and necessity for restrictive practices.

Option 2 involves:

- introducing a consistent streamlined authorisation approach for all proposed recipients (both adults and children with all forms of disability)
- Altering the role of appointed guardians for restrictive practices to be consulted by practitioners and providers during the assessment and planning stage but no longer have responsibility for providing consent to PBS plans.
- Disability Services, through the Chief Executive or their delegate, would authorise short term approvals and the use of mechanical, physical, and environmental restraints based on clinical expertise.
- QCAT would continue to authorise containment and seclusion given the gravity of these restrictive practices. However, given the ambiguity around LGDW (as these can be construed as containment) it may be that LGDW would also go to QCAT for authorisation.
- QCAT would hold oral hearings with multi-member panels with an advocate for the person with a disability being present.
- QCAT would continue undertake administrative reviews and appeals process pertaining to the restrictive practices' authorisation process (whereas complaints about the delivery of NDIS supports, including restrictive practices, would continue to be directed to the NDIS Commission) as QCAT is an appropriate merits review body.

Option 3: (preferred) Separating review and appeals from the authorisation

Option 3 proposes comprehensive process reform separating the authorisation process from the review and appeals process. This option:

- provides a uniform authorisation process for all types of restrictive practices and for all people with a disability (adults or children), removing the hierarchy of the restrictive practices
- Appoint an appropriately qualified Authorised Officer in Disability Services who would approve all restrictive practices including short term approvals based on clinical grounds
- Disability Services would undertake reviews promoting a step down in restrictive practices at each review
- QCAT acts only as an appeals body given it is the appropriate appeals body
- QCAT would hold oral hearings with multi-member panels with an advocate for the person with a disability being present.

It entails a uniform authorisation process for all types of Restrictive Practices for all types of disability where primary decisions are made by an Authorised Officer within Disability Services. This would enable the right tools, clinical expertise and experience to be at hand for the decision making. This

option would be more consistent with the models in Victoria and the Australian Capital Territory (ACT). It would allow a stronger focus on reduction and elimination, with the people making the authorisation decisions having the clinical skills, knowledge and expertise to confidently and professionally authorise in a consistent manner, and allow the sector to have a single point of accountability for restrictive practices.

Interim authorisation (short-term approvals) should continue to allow time for assessment, evaluate skills requirements of care staff, preparation of a PBS plan, and preparation of implementation notes to be undertaken before the final PBS plan is approved. Oral hearings and the involvement of the person with a disability would be required. QCAT would continue to provide an appeals process, independent of the authorising department.

Currently Disability Services is responsible for AS&RS until, under the NDIS transition agreement, it transitions from in kind in June 2023. Until then the number of PBS plan preparations by Disability Services for AS&RS is expected to grow to 205. Over the forward three years this would see Disability Services' overall number of authorisations grow to 951.

With cases only proceeding to QCAT on appeal, this would align with QCAT's broader role as an administrative review tribunal and retain an important safeguard of the current Queensland model. It would also provide a streamlined, simpler, more easily understood approach that stakeholders are calling for, as well as align with the draft National Principles. It is arguable that the loss of the procedural fairness protections associated with tribunal-level decision-making would amount to a reduction in safeguards, and this should be monitored in the transition phase. But this model would reduce the additional cost and complexity of QCAT being a primary decision-making body for certain restrictive practices. QCAT could continue to access external expertise to assist in decision making regarding appeals where necessary.

In this option, Community Visitors would not be required to take a system oversight role. They may continue to check if the PBS plan for the person concerned is current and could report this to the NDIS Commission. The Review notes that the Community Visitors role in relation to adults with impaired capacity is defined in the Public Guardian Act (ie an inquiry and complaint role s41 PGA) – as is the definition of visitable site. Regardless of the RP regulatory scheme, Community Visitors will continue to exercise their role at NDIS registered services that are visitable sites for the Public Guardian Act, including those where restrictive practices are used.

This proposed option moves the state's authorisation process from being shared across several agencies into one. This better utilises resources, clarifies risk holders and responsibilities. This proposed option also reflects societal attitude of respecting people's rights as the continuation of the journey of involving people with a disability in all decisions involving them and choice and control.

For both Options 2 and 3,

- The role of appointed guardians for restrictive practices would be able to consult with practitioners and providers during the assessment and planning stage but should no longer have responsibility for providing consent to PBS plans nor be involved in the decision to approve the restrictive practice. This would remove their conflict of interest and concerns about the level of clinical expertise required to understand and approve restrictive practices. It also removes the pressure on the OPG to have the clinical expertise required for the considerations undertaken as part of the approval process.
- Disability Services could choose to establish regional restrictive practices authorisation panels convened by delegates of the Authorised Officer (or the Chief Executive's delegates

for Option 2). Representation should include advocates for the person proposed to be subject to the restrictive practice, clinical practitioners, service providers and appointed guardians, but wherever possible, the active participation of the person concerned.

Conclusion

The Review of Queensland's Regulatory Framework for Positive Behaviour Support and Restrictive Practices has drawn upon a rapid but comprehensive review of both the grey and scholarly literature on the topics of restrictive practices and positive behaviour support, legislative comparison, alongside consultation with some of the key stakeholders to the regulatory system. Costs for the baseline, ideal state operation (no delays in the approval process) and other options were modelled.

On this basis, the Review can confidently assert that there is a rationale for reform of the regulatory framework in Queensland, even before considering the question of national consistency. This assertion rests on the following key observations, with implications for the statutory framework which regulates restrictive practices in Queensland:

- Since the passage of the QHRA there is a deepening understanding that the realisation of human rights and the implementation of a rights-based approach to service delivery requires commitment, vigilance and investment in access to advocacy, including building the capability for self-advocacy among people with a disability.
- There is increasing research and a growing body of practice knowledge about how to efficaciously assess individuals and their circumstances, develop strategies to address complex behaviours and implement these in different organisational contexts, which provide impetus to ongoing reforms to clinical governance, risk management and behaviour support and increased training among the relevant workforces.
- The commencement of the NDIS Commission and the NDIS RPBS Rules has resulted in inconsistency in definitions between the NDIS and the state has increased confusion within the disability sector.

Consequently, the Review's preferred option is Option 3. This option addresses the preferences identified in the consultation and recommended by the literature as contemporary practice:

- a streamlined authorisation process that safeguards both rights and wellbeing
- greater national consistency
- greater transparency, accountability and accessibility with respect to decision-making, monitoring, quality improvements and compliance
- support for practitioners and providers to make timely, efficacious and nuanced decisions to reduce the incidence and severity of complex behaviours of concern
- investment to support the active participation of people with a disability in the authorisation process, and
- building the capability of a growing services sector to activate PBS strategies and eliminate the use of restrictive practices.

The scope of the Review's analysis and consultation has been limited. Two groups of stakeholders were notably absent from the consultations due to the timeframes involved: 1) people with a disability, their networks and advocates, and 2) newer entrants to the market for Disability Services. The Review did not consult specifically with members of Aboriginal and Torres Strait islander communities, nor CALD communities. These consultations will occur in the next stage of refining options. Co-design processes could be used to re-imagining the processes for the authorisation of restrictive practices and to explore possible steps to realise the human rights of people affected.

Additionally, the Review was limited by not having access to the comprehensive data regarding the quality of PBS plans, nor data/metrics with which to assess whether there has been a reduction in the use of restrictive practices since the Carter reforms, relative to the numbers of people requiring disability service support.

The preferred option (Option 3) is consistent with stakeholder views and optimal practice identified in the literature for consideration.

Glossary

Approved restrictive practice	A restrictive practice that is used by a provider in relation to a participant, following a process through which the provider has sought, and obtained, formal permission to have the restrictive practice included in the participant's positive behaviour support plan, through the relevant state or territory approval process.
Behaviours of concern	Behaviours of such intensity, frequency or duration that the physical safety of the individual or others is likely to be placed in serious danger, or behaviour which is likely to limit the use of, or result in, the person being denied access to regular community facilities
Capacity (individual)	The understanding, skills and comprehension that aid individuals to exercise choice and control, and to participate in the community
Decision making supports	Activities, approaches and other supports that are designed to maximize participants' ability to exercise choice and control and to facilitate more opportunities for a participant to engage in decision-making in their everyday lives.
(the) Department	The Department of Communities, Disability Services and Seniors, Queensland Government.
NDIS participant plan	The plan approved by the NDIA CEO containing the participant's statement of goals and aspirations and the statement of participant supports.
Participant	(NDIS specific term) A person with a disability who has been assessed by the NDIA as meeting the eligibility criteria to participate in the NDIS.
Positive behaviour support	A range of proactive strategies implemented to identify and address the underlying causes of behaviours of concern through an individual functional behavioural assessment and development of a positive behaviour support plan. Positive behaviour support strategies may include implementing

changes to the environment and psychological interventions such as cognitive behavioural therapy.

Positive behaviour support

Plan

A positive behaviour support plan for a person with an intellectual or cognitive disability is a plan that describes the strategies to be used to:

- (a) meet that person's needs
- (b) support that person's development of skills
- (c) maximise opportunities through which a person can improve their quality of life
- (d) reduce the intensity, frequency and duration of behaviour that causes harm to the person or others.

The plan should also specify the conditions under which restrictive practices (if required) may be used.

Positive behaviour support

practitioner

An approved as an NDIS registered provider the can provide complex behaviour supports to NDIS participants. The PBS practitioner is required to demonstrate the ability to meet competency requirements relating to the development, implementation, review and monitoring of the positive behaviour support plan.

Registered Provider

An organisation registered with the NDIA to provide NDIS supports. Registered providers are bound by NDIA Terms of Business and other key policy frameworks such as NDIS Price Guide

Regulatory direction

A focus on the improvement of the safety and quality of support delivery that may include a combination of policies, registration, legislation, worker screening, supervision and development and monitoring and reporting.

Restrictive practice

Any intervention that restricts the rights or freedom of movement of a person with disability who displays behaviours of concern, where the primary purpose of that intervention is to protect them, or others, from harm. It is a

last resort intervention that occurs in the context of a positive behaviour support plan and should be used in proportion to the risk posed by the behaviour it is intended to address

Safeguarding

Arrangements that are devised to protect the rights of people to be safe from the risk of harm, abuse and neglect, while maximising the choice and control they have over their lives.

Substantive rights

Basic human rights such as life, liberty, or property, recognised for its own sake.

Supports

Services, assistance and products required by an NDIS participant to address the impact of a disability. Supports can include mainstream services, assistance from family, carers, friends and NDIS funded items such as supports to access employment support.

Acronyms

ACT Australian Capital Territory

LGDW Locked Gates, Doors, Windows

DSS Department of Social Services (Australian Government)

DISABILITY SERVICES Department of Communities, Disability Services and Seniors (Queensland Government)

NDIS National Disability Insurance Scheme

NDIA National Disability Insurance Agency

PBS Positive Behaviour Support

PS PLANS Positive Behaviour Support Plan

QCAT	Queensland Civil and Administrative Tribunal
RP	Restrictive Practices
RPPB	Restrictive Practices Positive Behaviour
STA	Short-term approvals
OPG	Office of the Public Guardian
OPA	Office of the Public Advocate

Appendix Terms of Reference for the independent review

This Independent Review was asked to consider the following:

- The draft shared principles for national consistency in restrictive practices authorisation that have been developed for DRC consideration;
- The restrictive practices authorisation frameworks in place in the other Australian states and territories;
- The current function of the chief executive (Disability Services) to decide whether a multidisciplinary assessment of an adult will be conducted and developing positive behaviour support plans that include containment and/or seclusion (under the DSA, part 6, division 3, subdivisions 2 and 3);
- The principles of choice and control under the NDIS;-The application of the division in relation to the 'locking of gates, doors and windows' to prevent physical harm being caused to an adult with a skills deficit (section 216 of the DSA);
- The definitions of restrictive practices (section 144 of the DSA), in light of the definition of 'a regulated restrictive practice' in the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018;
- The cohort of NDIS participants to whom Queensland's authorisation processes for the use of the restrictive practices should apply taking into account the NDIS RPBS Rules that extend regulate onto all NDIS participants (adults with a disability other than intellectual or cognitive disability, and children with a disability);
- The consent/approval process for the use of restrictive practices under the DSA and GAA (including short-term approvals), specifically who can provide consent/approval and the relevant decision-making criteria;
- The circumstances in which restrictive practices can be authorised (including immunity provisions), including whether there are any restrictive practices that should be prohibited;- The role of the Chief Executive, DISABILITY SERVICES, the Public Guardian and QCAT in the authorisation process and the impact on these entities of any proposed changes to the authorisation process;
- The capacity and capability of the market to respond to any expansion or changes to the authorisation process in Queensland, including the requirement for a positive behaviour support plan to be prepared;
- Issues arising from the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability; and
- Any other work being undertaken by the National Quality and Safeguards Commission or work for the purpose of the National Disability Insurance Scheme to assist Australian states and territories in promoting and developing the market for specialist behaviour support practitioners.

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