



COMMUNITY SUPPORT AND SERVICES COMMITTEE

Members present:

Mr A Tantari MP—Chair
Mr SA Bennett MP
Mr MC Berkman MP
Mr JR Martin MP
Mr JP Lister MP
Mr RCJ Skelton MP

Staff present:

Ms L Pretty—Committee Secretary
Ms A Bonenfant—Assistant Committee Secretary

PUBLIC HEARING—INQUIRY INTO THE DISABILITY SERVICES (RESTRICTIVE PRACTICES) AND OTHER LEGISLATION AMENDMENT BILL 2024

TRANSCRIPT OF PROCEEDINGS

Friday, 19 July 2024

Brisbane

FRIDAY, 19 JULY 2024

The committee met at 1.45 pm.

CHAIR: Good afternoon. I declare open this public hearing for the committee's inquiry into the Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2024. My name is Adrian Tantari, member for Hervey Bay and chair of the committee. I would like to respectfully acknowledge the traditional custodians of the land on which we meet today and pay our respects to elders past and present. We are fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander people whose lands, winds and waters we all share. Other committee members with me here today are Mr Stephen Bennett MP, member for Burnett and deputy chair; Mr Michael Berkman MP, member for Maiwar; Mr Robert Skelton MP, member for Nicklin; Mr James Martin MP, member for Stretton, who is substituting for Cynthia Lui MP, member for Cook; and Mr James Lister MP, member for Southern Downs, who is substituting for Dr Mark Robinson MP, member for Oodgeroo.

This hearing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Only the committee and invited witnesses may participate in the proceedings. Witnesses are not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a serious offence. I also remind members of the public that they may be excluded from the hearing at the discretion of the committee. These proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the committee's media rules and the chair's direction at all times. You may be filmed or photographed during the proceedings and images may also appear on the parliament's website or social media pages. I ask you to turn your mobile phones off or to silent mode.

CHESTERMAN, Dr John, Public Advocate, Office of the Public Advocate

MATSUYAMA, Mr Yuu, Senior Legal Officer, Office of the Public Advocate

CHAIR: I now welcome the Public Advocate for Queensland and representatives from the Office of the Public Advocate. Good afternoon, Dr Chesterman. Would you like to make an opening statement before we start our questions?

Dr Chesterman: I would. Thank you very much. Thank you for the opportunity to be here to speak about the Disability Services (Restrictive Practices) and Other Legislation Amendment Bill. I also acknowledge that we are on the traditional lands of the Turrbal and Yagara peoples and I pay my respects to elders past, present and emerging.

As members of the committee know, as the Public Advocate for Queensland I undertake systemic advocacy to promote and protect the rights and interests of Queensland adults with impaired decision-making ability. There are several conditions that may affect a person's decision-making ability. These include intellectual disability, acquired brain injury, mental illness, neurological disorders such as dementia, or alcohol and drug misuse.

As members would note from my submission, I have keenly supported the development of a new Senior Practitioner-led restrictive practices authorisation framework for people with disability in Queensland. Almost from the day I started as the Public Advocate in August 2021 I have advocated for this development. I have also advocated for a Senior Practitioner-led restrictive practices authorisation framework to reach into other fields beyond disability services, such as the aged-care sector.

A preliminary comment I would make is that the enactment of this bill would and will be a significant human rights development here in Queensland. As I noted earlier, my role concerns advocacy on behalf of adults with cognitive disability, so I have not in my submission addressed the bill's provisions regarding children. Committee members will know from my submission that I have a number of thoughts about the bill, of which I am, of course, broadly supportive.

One key point I make in the submission is that this proposed new and far superior model of authorising restrictive practices than what we have now must not become a way of regularising the use of restrictive practices. The aim must be to reduce and eliminate their usage. While the bill has a number of clauses that mention this goal, I observe here that the Senior Practitioner will carry significant responsibility for leading the sector on a reduction and elimination pathway.

In my submission on the bill I have made a number of improvement suggestions. I will briefly highlight those here. The first is that the foundational requirement for a disability services restrictive practice to be authorised needs, in my view, to be strengthened. I have suggested drawing from Victoria's provision in this regard.

My next point is that it is somewhat unclear what the consequences will be for the use of an unauthorised restrictive practice. It appears that this will be left to general laws, such as assault and deprivation of liberty, or to regulatory action by the NDIS Quality and Safeguards Commission. One provision suggests there could be criminal and civil liability for the continued use of a regulated restrictive practice if an application to the Senior Practitioner is refused, but the legislation is silent generally on the consequences for the unauthorised use of a restrictive practice. In my view this should change.

My next point concerns the workload of the Senior Practitioner which will be high. As I mentioned in my submission, in the proposed scheme there will not be local restrictive practices authorisers as there are, for instance, in Victoria. Instead, the Senior Practitioner will be responsible for authorising all regulated restrictive practices, so the workload will be high.

I have also suggested that the Senior Practitioner be given stronger powers. While the bill does give the Senior Practitioner a range of powers, including the ability to do 'all things necessary or convenient to be done' in the performance of their functions, the Senior Practitioner again, for instance, in Victoria has powers such as to 'give directions' and to visit premises and order the discontinuation of restrictive practices. I think that is worth emulating here. I have also suggested that the power of the Senior Practitioner to cancel a restrictive practices authorisation be slightly extended to situations where there is simply no longer a need for the use of a regulated restrictive practice.

My final introductory point is that the workability of this new scheme will stand or fall on two things: first, the ability of the Senior Practitioner and their office to lead a restrictive practices reduction and elimination agenda through the authorisation and sector leadership roles; and, second, the extent to which behaviour support plans and behaviour support planning embody and promote a least restrictive and positive approach to understanding and managing people's ways of expressing themselves. Behaviour support planning cannot just be about filling in a form to justify the use of a restrictive practice; the quality of behaviour support plans will be crucial.

I have made other points in my submission about information disclosure and the potential applicability of the scheme to other fields, but I will not elaborate on those here. I do support this legislation. This is a much needed change. In awareness of the timeframe available for the potential passage of the legislation and knowing as I do the drafting and other challenges that the introduction of a new system like this poses, it seems apt to encourage us to press on and to reference Voltaire in commenting that we must not let the perfect be the enemy of the good. I will stop there and invite member questions and observations. Thanks for having me here.

CHAIR: Thank you, Dr Chesterman. I call the member for Burnett for the first question.

Mr BENNETT: There seems to me to be a lack of clarity around what is deemed a restrictive practice. We are potentially talking about people with disability here—in essence, adult people with disability, as you quite rightly mentioned. Is there a lack of clarity around what is seen as a restrictive practice in Queensland and how the implementation of the bill would be seen by those practitioners within the field?

Dr Chesterman: No. I think the bill's definition of regulated restrictive practices is similar to what we have nationally now, so that is becoming wider and wider known. I am just looking at the definition. There are five kinds of restrictive practices—chemical, mechanical, environmental and physical restraint, and seclusion. I think in the sector those are more and more widely understood. I agree with the bill's encapsulation of those.

The challenge we will have is rolling out a new authorisation framework. Proposed new section 140 provides that this would apply to registered NDIS service providers, funded service providers, the department itself and other service providers prescribed by regulation. It is a new scheme we are moving to away from what is essentially a consent-based model and a guardianship/consent-based model. This is a far superior model, but there will be implementation challenges for sure.

Mr BENNETT: With those definitions within the bill that you have just alluded to, are there still going to be issues with identifying violence against a person with a disability and how we constitute that that is actually a breach of that restrictive practice? There has been a lot written about what violence to those vulnerable Queenslanders looks like. I am curious to hear your opinion.

Dr Chesterman: Yes. This is a significant issue. If you imagine a situation where someone is acting in a manner that then leads to a service provider or family member or someone else constraining a person in some way, where is the line between acting appropriately, for instance, in self-defence or protecting a person from harm—stopping them running on to a road, for instance—something in an immediate circumstance and something more longer term? There are areas of grey. There is no question. What I would say though is that there are areas also where it is not grey where we are clearly seeing someone subject to a restriction on their movement that needs to be authorised and regulated in an appropriate way.

Mr BENNETT: Or quote Voltaire.

Dr Chesterman: Yes.

Mr MARTIN: You mentioned you supported moving towards reducing restrictive practices but also eliminating them. Do you accept that there are situations where restrictive practice cannot be eliminated, especially if someone might be at risk of harming themselves or a staff member or a disability support worker? Surely there are going to be some restrictive practices which will have to continue indefinitely.

Dr Chesterman: Yes, I do accept that. What we are doing in bringing in this new regime is introducing clinical expertise on behavioural management. I have experienced that there are situations where people may say, 'In this circumstance this person is always going to be subject to a restrictive practice,' and, in fact, they are not because something can happen. All behaviours are a form of communication. Sometimes we do not know what it is that a person with a significant cognitive disability is trying to communicate—why they are acting in the way they are. I know of situations where a person has been subject to restrictions and unbeknownst to others they have had an ear infection and they are acting out of pain. There are all sorts of circumstances. That is a longwinded way of answering. I agree: I think we need an authorisation framework. The idea that there will be no restrictive practices is fanciful.

Mr BERKMAN: I appreciate your time here today. If I have read your submission properly, it frames it up that one of the real challenges here is that this framework does not become a way of normalising or regularising the use of restrictive practices. Can you elaborate on that for us and maybe touch on some of the ways that you see we might best minimise that risk?

Dr Chesterman: It is a real danger that when you start regulating something in a new way you do not regularise it. First, the reason I have advocated for the change to this new regime is that there are significant problems with what we call a consent model to authorise restrictive practices—where either a person themselves consents or someone consents on their behalf. That is what we have at the moment in the aged-care sector and we have had in the disability services sector largely in Queensland. There are all sorts of philosophical and ethical problems with asking someone to consent to their own restrictive practice or asking someone else to step into their shoes and consent on their behalf. There are all sorts of reasons why that just does not work.

We are moving to this new model where you have an Office of the Senior Practitioner who is responsible for authorising. What you are wanting to do by creating that position is have someone with the expertise in behaviour management to be able to drive down restrictive practice usage, and they would do that with their educational role and with their authorisation role that they have when applications come to them. They can look at the application and say, 'Has everything less restrictive been tried? Have you tried this?' bringing that kind of clinical oversight into the process. It offers the real potential to drive down restrictive practices usage. If those powers are not exercised, it could regularise the usage just by providing a tick-a-box way of proceeding. That is to be avoided. I do not think it is going to happen, but it is a risk.

Mr BERKMAN: If I understand your response, a lot of it really does come down to the Senior Practitioner—the individual in and around that role?

Dr Chesterman: Yes, I think that is right. There is a significant potential in the role and significant educative abilities that they will have to drive down restrictive practices usage, and a lot will come down to how the powers of the Senior Practitioner are exercised.

Mr SKELTON: Dr Chesterman, the royal commission report and you both say that restrictive practices should only be used as a last resort and be the least restrictive as possible and for the shortest time possible, and understandably so. What alternatives though are available instead of restrictive practices?

Dr Chesterman: It depends on the timeframe that we are talking about. Sometimes in essential and emergency situations service providers, family members and others can find very few alternatives, but longer term the ways in which restrictive practices can be minimised include understanding the person—we are almost always talking about someone with significant cognitive impairment—and understanding their likes and their dislikes, because failure to understand those and to enhance wherever possible the ability of the person to communicate those in non-violent ways is the way in which we can avoid many situations where restrictive practices become the almost inevitable outcome. That is a broad answer to your question.

Mr SKELTON: From my understanding of the answer, what you are saying is understanding the diagnosis of a person, their behaviours and what triggers them and putting practices in place where that does not happen means that we do not have to resort to the last option of using a restrictive practice because we are mitigating the circumstances where that might occur.

Dr Chesterman: That is right. Just to give you an example, you might have a person who has a significant cognitive impairment who has a regular staff member who sees them and knows that they like a particular food for breakfast. Suddenly there is a gap in the staffing and a casual staff member comes in and does not give the person the breakfast that they are used to and that can lead to an escalation of behaviours which could all have been avoided if we had known what the person wanted for breakfast.

Mr SKELTON: Thank you for your answer, Dr Chesterman. My wife is an aged-care nurse and deals with a lot of people with dementia. What you have just described is exactly the sort of thing that they do in practice to prevent having to resort to a restrictive practice, so thank you.

Mr BENNETT: In your advocacy and movements around the sector and with regard to the reporting requirements for possible breaches of human rights or allegations of restrictive practices not being appropriate, is there a large statistical number of those sorts of issues that you have been made aware of?

Dr Chesterman: Yes, an enormous number. The NDIS Quality and Safeguards Commission in fact reports on the number of unauthorised uses of restrictive practices nationally and the number one year exceeded—I am trying to think of the figure. I will not quote a wrong figure, but it was a very high figure.

Mr BENNETT: Were these proven breaches though or just allegations?

Dr Chesterman: Yes, these were breaches that the commission has been alerted to, often by service providers in terms of their own failings, so the number is enormous, and we are talking at the moment just about the disability services field. When you reach into other fields, including in education and health settings and aged care, the number is enormous.

Mr MARTIN: Dr Chesterman, I just wanted to ask about the difference between the consent model and effectively moving towards a clinical model. My understanding is that there would be a lot of restrictive practices currently in place because of the consent model. As we move to a clinical model, in your opinion will there be thousands of restrictive practices lifted? What do you see happening?

Dr Chesterman: In the immediate move to the new system the number would be similar or even higher in terms of authorisations, because currently we have in Queensland some ways in which in the disability services field there can be informal consent given, so non-reported consent given to what we call environmental restraints. Longer term, when you move to a new regulatory system sometimes you can see a rise because the reach is greater and the information is better disseminated, but then you would see a drop as this clinical expert model takes over because you do have that expert advice being given to providers about alternatives to the use of restrictive practices.

Mr MARTIN: Might there be some challenges between, say, someone who has been in a house for a long time with long-term staff members who have always locked the door so that the resident could not escape and run down the street—it has always been that way—and then a clinical view of that may then remove that? That could cause a little bit of friction in disability houses around the place.

Dr Chesterman: It could, but if the reason for the locked door was warranted in terms of the person being in an immediate road safety threat then that could be continued under the new scheme. The point that I would make is that the important difference would be we are getting some other expert eyes over what is happening there, because a lot is done currently in the name of 'this is the only thing we can do'. Bringing clinical expertise into the picture gives rise to the possibility that there might be other ways in which we can manage a person's behaviour or get them to manage their own behaviour in a way that does not involve restricting their freedom to move about in that circumstance.

Mr MARTIN: But a clinical decision to put in a restrictive practice would still take into consideration long-term carers and employees; it would have to, I would assume?

Dr Chesterman: Yes, very much. The focus of any restrictive practices authorisation regime is on the person, and obviously when there is violence there are occupational health and safety issues for the providers as well. I would not be wanting to meet those through this environment. You have to meet that through other areas and the two can interrelate obviously, but the focus needs to be on the person and doing things that essentially protect them. That is what it is about.

Mr BERKMAN: Dr Chesterman, your submission notes that there is no legal consequence for a personal provider who uses a restrictive practice where it is not authorised. Can you just elaborate for us on your concerns around that omission or that absence in the bill?

Dr Chesterman: Sure. The bill at one point refers to potential civil and criminal liability, and there are provisions in the Criminal Code around the deprivation of liberty and so on which could be utilised to punish a provider who has not followed the authorisation regime. My point would be, though, that those provisions are there now. They are very rarely used in relation to restrictive practices. I think it is quite important as standard setting to make it clear in the bill that to not follow the authorisation regime would be an offence and to list a penalty there. The example I would give is Victoria, which does that. They have a penalty of 240 penalty units for the unauthorised use of a restrictive practice as a standard setting point. We need to be clear that where you have an authorisation model to not follow it is a significant wrong.

Mr BERKMAN: You seem quite clear in your view that you do not imagine those existing provisions around deprivation of liberty being applied. The creation of this framework does not make it any more likely that those will be adopted and applied.

Dr Chesterman: That is correct, I think. That is right. They could be applied, but they are not currently being applied to the use of restrictive practices and I think they are unlikely to be in the immediate future. That could change, but my advocacy would be to have a specific offence just to make it clear that this is not an optional thing; people are required to follow this authorisation framework.

CHAIR: Dr Chesterman, with regard to the BSPs, or the behaviour support plans, contained within the bill is the removal or requirement of the chief executive of a disability service to prepare these. That will allow these plans to be prepared by market-based providers. Do you have any concerns regarding that sort of option being put into place?

Dr Chesterman: As a general comment, the quality of behaviour support plans generally in Australia is very low, so I do have concerns. This is a nationwide issue. We need to improve the quality of our behaviour support planning and that requires significant market intervention. I know federally the National Disability Insurance Agency is aware of this, as is the NDIS Quality and Safeguards Commission, and they are trying to promote the market here. The low standard here is one of the reasons why we would be moving in this legislation to have the Senior Practitioner authorise all restrictive practices in the disability sector rather than having, as you do, for instance, in Victoria, local area authorisers who are basically registered with the Senior Practitioner but employed elsewhere who are given the power to authorise restrictive practices. Because of our relative immaturity of the market we are not going down that model, and I think that is probably the right call. To answer your question, I do have concerns about that and think that is one key area where the Senior Practitioner, if the scheme is adopted, would want to focus a considerable amount of energy.

Mr BENNETT: You mentioned a list of restrictive practices, and I think there are some reports that have those. Do you see that list being expanded? You mentioned the NDIA and NDIS providers. Would it be fair if a restrictive practice could be, in essence, failure to provide the suite of services that they are being procured to do—turning up late, not doing what the client expects and all of those sorts of things? That is a debate for another day, but I guess it is still a restrictive practice though.

Dr Chesterman: It could be if a person, for instance, is constrained in their movement in a house and they are used to getting up at seven o'clock and no-one comes to get them up and they are left in some way unable to access things like breakfast. You would hope that they would not be locked in their room, but if there are locked cupboards to stop them accessing food whereas normally they would be unlocked and the service provider does not turn up then it could be.

Mr BENNETT: Yes, because in the work that we did when we were travelling around on the supported accommodation issue we heard horror stories about providers sitting in their cars out the front turning up to talk to clients and all these things. I was just thinking then about that work and the work that you prompted the committee to look at. It was very restrictive because those people were socially isolated, if nothing else.

Dr Chesterman: Yes, indeed, and we hear horror stories. I heard one person in my office this morning talking about situations in private homes where restrictive practices are used which are extraordinary actually. This is a big problem.

Mr BENNETT: So that is not an exhaustive list as you see it and the practitioner will make a determination to their understanding about what is deemed and what is not?

Dr Chesterman: Certainly, and the Senior Practitioner will have a role in developing the guidelines and so on for people to say this is and this is not.

Mr BERKMAN: We have spoken a bit about the role of the Senior Practitioner and your submission supports the expansion of that role into other sectors, but I am interested in the concerns around the scale of the workload for this role. Do you have any suggestions for the committee around how that could be best managed to avoid a backlog of cases for review?

Dr Chesterman: Yes, that is a good question. One way would be to think about the review mechanisms of how the scheme is going. Off the top of my head the review of the legislation would be in-built—

Mr Matsuyama: I believe it was, but I am not sure exactly.

Dr Chesterman: Building in a review of the legislation and how operations are going will be very important to see how the office is going. Being inundated will cause severe problems that might not see the scheme realise its potential. That is a concern I have.

CHAIR: Our time has expired. Thank you both for presenting your evidence to the committee today and thank you for your attendance.

FULTON, Ms Sarah, Principal Lawyer, Queensland Human Rights Commission

LEONG, Ms Rebekah, Principal Lawyer, Queensland Human Rights Commission

CHAIR: I welcome representatives from the Queensland Human Rights Commission. Would you like to make an opening statement before we start our questions?

Ms Leong: Thank you very much. I acknowledge the traditional custodians of the land on which we meet today, the Yagara and Turrbal people, and pay my respects to elders past and present. I thank the committee for the opportunity to speak to the Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2024. The commission supports the passage of the bill.

Restrictive practices can have a significant, long-term negative impact on a person's human rights and humanity. It is a measure that is only used in relation to people with disability. The limitation of human rights caused by restrictive practices is said to be justified for the purpose of preventing harm to people with disability and to others. However, restrictive practices should never become routine and must always be the least restrictive way of supporting safety and improving quality of life and have as an overarching objective the elimination of their use.

The bill has been introduced following many years of review and consultation by the department. The effort to simplify and streamline the Queensland authorisation framework with National Disability Insurance Scheme requirements will enhance accountability, transparency and efficiency and improve safeguards for people subject to restrictive practices. The establishment of a Senior Practitioner model that will authorise the use of restrictive practices, together with functions to provide expertise, advice and collect data on the use of restrictive practices, also provides opportunities for the independent scrutiny of the use of restrictive practices in Queensland both individually and systemically. This will support the sector to genuinely move towards minimising and eliminating the need for restrictive practices.

The bill expands the current scope of authorisation for restrictive practices to all persons, adults and children, who receive Queensland government funded or NDIS funded disability supports. The expansion of protections is welcome, but the commission notes that many other areas in which restrictive practices occur will not benefit from these changes such as health care, aged care and schools. Once the new model is established and evaluated, consideration should be given to if and how it can be expanded to provide all people with disability with consistent safeguards and protection, no matter what services or systems they encounter.

In addition to the recommendations made by the commission in its written submissions, the commission notes that the policy objectives of the bill must be underpinned by adequate resourcing of the Senior Practitioner's office not only in relation to their authorisation functions but also in relation to providing education and advice and responding to complaints. In this regard, the commission notes that other submissions made to this committee have highlighted the need for sector-wide training and cultural change if a real reduction in the use of restrictive practices is to occur. This includes trauma informed practice, alternatives to restrictive practices, positive behaviour support and human rights. Service providers would also need to be resourced to build this capacity.

Finally, the commission echoes the Public Advocate's recommendation that the use of restrictive practices—when contravening the authorisation framework—be made an offence under the Disability Services Act. This reinforces the seriousness of the breach and overcomes hurdles that might exist in demonstrating civil or criminal liabilities under other laws. Enforceability also assists to fulfil human rights obligations to provide a framework that prevents torture and ill-treatment and protects vulnerable people from harm.

Mr BENNETT: The Public Advocate deals with adults, and I note that your submission obviously identifies a broader range of those people in our community who would be affected by some of these issues. This question is similar to one I asked the Public Advocate: statistically, what sorts of numbers of people affected by the more perverse restrictive practices has the Human Rights Commission seen?

Ms Leong: I was just speaking to my colleague as we were sitting here listening, and that is a statistic I probably should have looked up before coming to the committee. One thing the committee may be aware of is that we have a complaints function where we can receive complaints about public entities for alleged breaches of human rights. That includes NDIS service providers and it also includes the department. If people with disability have allegations of breaches of human rights, we could accept complaints in relation to that and seek to resolve those complaints through conciliation. I am not aware of the number of complaints made in that respect.

Mr BENNETT: In a similar vein, do you also accept that the scope of what is a restrictive practice is somewhat unquantifiable?

Ms Leong: I think the term 'restrictive practice' has been around for a while. We have, as the Public Advocate indicated, picked up the definitions from the national framework, so I think there is a growing knowledge and understanding and expertise around what meets the definition of 'restrictive practices'.

Mr BENNETT: Are you saying it is definitive? There are half a dozen things, including mechanical and environmental. As I said before, it could be something around—

Ms Leong: Sure, and I think it is right that we will never be able to definitively list out everything that might amount to a restrictive practice. As the Queensland Human Rights Commission, we are not on the ground in terms of—

Mr BENNETT: The Senior Practitioner has his or her work cut out for them.

Ms Leong: Correct.

CHAIR: Member for Burnett, would you like a question on notice regarding statistics?

Mr BENNETT: If it is not too much work. To get a grasp of what we are doing, yes, could we get an idea of the number of breaches that are reported?

Ms Leong: The commission can try and draw the statistics on the types of complaints that we receive that are relevant to this hearing.

CHAIR: Thank you.

Mr MARTIN: I just wanted to ask you, as representatives of the Queensland Human Rights Commission, a little bit about a grey area the committee heard about. How do you weigh up the human rights of a person with a disability having unfair restrictions put on them with somebody's right to attend a safe workplace that is covered by workplace health and safety? Are you comfortable with where the bill has come in relation to this?

Ms Leong: Yes, I think the criteria set out in the bill that the Senior Practitioner has to consider when authorising a restrictive practice highlight the importance of considering the rights of the individual who is subject to the restrictive practice balanced against other issues. The human rights framework will provide an additional overlay on the requirements of the Disability Services Act. Both the NDIS provider and the department service provider are public entities with obligations under human rights. The Senior Practitioner will also be a public entity with obligations under human rights and a human rights framework would look at what rights of the individual have been impacted and whether they have been justified. The justification comes from the purpose, and the purpose is to reduce harm to the person themselves but also to the people working with them and around them and then finding the balance—firstly, making sure that the restriction has a connection to the purpose and making sure that the restriction is actually going to prevent harm, which is its purpose, is least restrictive and then, finally, making sure that it is proportionate, so making sure that the restriction does not outweigh the purpose of the limitation.

Mr MARTIN: You mentioned penalties in your submission. Who would they apply to? They would apply to the frontline workers, would they not?

Ms Leong: The service provider. I can understand a reluctance not to maybe pinpoint individuals within that service provider, but the reason why we think it would be appropriate to include penalty provisions specifically under the Disability Services Act is again to be very clear about how serious a breach of the framework is. There are also legal criteria and legal tests existing under criminal and civil laws which might impose too high a bar for a person with disability or somebody acting on their behalf to prove, so having the penalty within the Disability Services Act and having clear criteria under that might just increase the enforceability of those obligations under the DSA.

Mr BERKMAN: Just on that point, I think it is instructive to hear both the Public Advocate and yourselves floating the absence of any legal consequence. Can you offer a suggestion as to what might be an appropriate penalty to include for noncompliance in the use of restrictive practices?

Ms Leong: I really could not comment on that.

Mr BERKMAN: You mentioned in your submission that the seclusion of children should be prohibited as a restrictive practice as part of that list to be prescribed by regulation. I am just curious whether the commission has been consulted on any draft list of prohibited restrictive practices.

Ms Leong: From memory, in the consultation period I think there was a question put to all of the people consulted about what should be included and what should not. I think the decision has been made to put it into the regulation. I think in the government's response to the submissions they

have also indicated there will be further consultation in the preparation of the regulations. I also note that the disability royal commission has already had a go at a fairly comprehensive list of practices they think should be prohibited.

Mr BERKMAN: Does that include the seclusion of children?

Ms Leong: Correct, yes.

Mr SKELTON: We heard from the Public Advocate and he suggested that the Senior Practitioner would be quite busy doing supervising and education around restrictive practices. He pointed to a model in Victoria where they have local authorities that do such a thing. How would we do something similar in a state as decentralised as Queensland? I can imagine the workload will be huge, particularly because, as you have already alluded to, restrictive practices are not just affecting people who are disabled and ongoing work needs to occur in other sectors. Do you have any suggestions as to what could empower government to push that along?

Ms Leong: To push out further protections for people in other sectors who are affected by restrictive practices? I think I alluded to this in my opening statement. This is a new model for Queensland. If the bill is passed and it is rolled out, there is an opportunity there to evaluate how it is going and what works and what does not work, and then I think that is a good opportunity to see what you can then tailor to other sectors to make sure the protections can be expanded and the knowledge and expertise can be expanded to other areas so people are protected. One of the concerns we have in this bill only applying to NDIS service providers and Queensland department disability service providers is that a person with disability is not just engaging with those services; they are engaging with all of these other services and they might come across different regimes or different criteria or different understandings. It just gets very complex for any person, let alone a person with disability, to navigate. It would be an improvement if there could be consistency across the board.

Mr BENNETT: I feel somewhat uninformed, but is anyone approving restrictive practices currently? Do clients have some sort of management plan? Say they are living in assisted accommodation with a disability or some other impairment, do they have some sort of restrictive practice? If a provider wants or needs to use that currently, is there some sort of authorisation or approval for that currently?

Ms Leong: Assisted accommodation might not be a good example.

Mr BENNETT: Can you give me another example?

Ms Leong: Under the current Guardianship and Administration Act, there is a regime for people with cognitive disability to get a restrictive practice guardian appointed by QCAT. That guardian consents to the use of restrictive practices. The oversight framework is in relation to appointing that guardian.

Mr BENNETT: In your submission you reference behavioural support planning. Does that exist now?

Ms Leong: Yes. My understanding is that that plan has to be prepared in order to be appointed a guardian or to use seclusion or containment.

Mr BENNETT: It is hardly a subtle change, but the Senior Practitioner now would take some oversight of that particular process and the management of that client resident?

Ms Leong: Yes, so instead of relying on, say, the Public Guardian or a family member to consent to the use of restrictive practices, we now get the service provider making an application to the Senior Practitioner who can cast their expert eye over the application and then authorise. I think a really important part of the regime is that not only can they authorise but they can also authorise with conditions so they can help service providers to improve how they go about business.

CHAIR: I note in your submission you have a heading, 'Human rights principles for people with disability should expressly include protection against torture'. This relates to sections 17 and 18, which are set out. In particular, you recommend that section 18 should be amended to expressly refer to certain human rights. I assume that that is with regard to that heading. I note that the department has responded to your submission by stating that—

... the reformed authorisation framework provides in-built safeguards to ensure any limitation on a person's human rights are done so to protect the person with disability from harm or harming others.

Do you think that is sufficient protection for a person's human rights?

Ms Leong: I have already said that most of the stakeholders in this space will already be subject to the Human Rights Act requirements, including acting compatibly with human rights, including the protection against torture. I guess the value of including that particular section or that

human right within the principles is that the act has gone to the effort of defining these particular principles in relation to the Disability Services Act and the use of restrictive practices. I think it is important that if you are going to articulate or highlight particular principles then you should be highlighting all the really important ones. In relation to restrictive practices, the right against torture and cruel, inhumane or degrading treatment is one of the key principles that we should be considering in authorising restrictive practices. I think it just reinforces the importance of that right. They would still have to apply the Human Rights Act but placing it front and centre in the Disability Services Act highlights its importance to the regime.

Mr BERKMAN: Another point in common between your submission and that of the Public Advocate was around the suggestion that there should be broader discretionary powers to cancel authorisations. Can you flesh that out a little more for us? What deficiencies are there in the current provisions for cancellation? What do you think that discretionary power should look like?

Ms Leong: At the moment the discretion to cancel authorisation specifically identifies three grounds, from memory: a contravention of a condition of the authorisation, a contravention of a provision of the Disability Services Act and I think there was a third one that I cannot draw my mind to. There are no broad discretions then to just look at a person's circumstances and what is happening for them, whether restrictive practices are still needed even, and just cancel on those more broad grounds in the particular circumstances of the case. I guess the worry is that the current grounds that are set out in the bill might not cover off on all the situations where you might want power to have the ability to cancel an authorisation in the circumstances. In the department's response to the submissions they do say that there are a lot of criteria that the Senior Practitioner has to apply before they authorise a restrictive practice, so contravention of any of those could potentially result in a cancellation. There is probably quite a lot of ability to cancel in most situations but, in order to make sure that the rights of people with disability are safeguarded, we would still recommend that there be a broad discretion to cancel in the appropriate circumstances.

Mr BERKMAN: Are you aware of any broad principle that might already offer that power? I have this vague recollection of some principle where the power to make a decision carries with it an inherent power to reverse or to make a different decision in the future.

Ms Leong: I think I understand where you are going. There might well be, but I am probably not in a position to comment on that. When you have a provision that says, 'Here's where you have discretion to cancel it', it would be good to articulate all the grounds.

Mr BERKMAN: To make it clear, yes.

Mr MARTIN: I hope this is not too hypothetical a question. I have a question about restrictive practices in general and human rights. Restrictive practices can restrict the right of a person with disability and that can be justified based on something that causes harm to themselves or harm to others. What about products that are legal that cause harm? Does a person with a disability have the right to smoke a pack of cigarettes a day and eat heaps of sweets or junk food? What is the human rights position there?

Ms Leong: I think there is a dignity of risk question here. A person subjected to restrictive practices is still a person with their own views, preferences and wishes. If we look at the person just as a person, we all have the right to go out and do bad things to ourselves or unhealthy things. I feel restricting a person with disability from making the same choices that anyone else would have the ability to make is something that should not be authorised.

Mr BERKMAN: Can you elaborate on what additional functions you think might be ascribed to the Senior Practitioner to review the authorisation framework and identify systemic improvements?

Ms Leong: I appreciate that there is some overlap here with the NDIS Quality and Safeguards commission's functions, which I am not an expert in. Given the role that the Senior Practitioner will have in Queensland and the oversight they will have on the authorisation of all restrictive practices in Queensland, there is a real opportunity for them to use that expertise and the data they will have access to to consider improvements to the authorisation framework, the way that they support the sector in using restrictive practices and how they can facilitate better use of alternatives or thinking more broadly about how else the outcomes can be achieved without using restrictive practices.

CHAIR: As there are no further questions, I thank you for coming along this afternoon and presenting your evidence to the committee.

VEERABHADRA, Mr Vinay, Senior Solicitor, Queensland Advocacy for Inclusion

WIGGANS, Ms Sophie, Principal Systems Advocate, Queensland Advocacy for Inclusion

CHAIR: I welcome representatives from Queensland Advocacy for Inclusion. Would you like to make an opening statement before we ask questions?

Ms Wiggans: Thank you very much for the opportunity to appear before the committee today. We would like to begin by acknowledging the traditional owners of the land on which we meet, the Turrbal and Yagara peoples. We acknowledge the lives of First Nations Australians with disability and the intersectional disadvantage they experience. We pay our respects to elders past and present and, in particular, to our president, Byron Albury.

As you know, QAI is an advocacy organisation and a specialist community legal centre for people with disability in Queensland. We provide, among other things, legal advice and representation to people with disability who are subjected to restrictive practices. The use of restrictive practices substantially impacts on the rights and freedoms of people with disability. Restrictive practices also significantly affect the physical and emotional wellbeing of those who are subjected to them. Concerningly, we know that restrictive practices are used too frequently and often inappropriately. Having a robust authorisation framework and associated oversight mechanism is therefore essential to ensuring that restrictive practices are used only as a last resort measure within a framework that is genuinely working towards reducing and ultimately eliminating their use.

As such, the QAI welcomes this bill and the improvements to the authorisation framework that it introduces, including the establishment of a Senior Practitioner model. Our written submission, as well as the submissions of other witnesses here today, provides the committee with suggested amendments that will improve the implementation of this change. The suggested amendments also provide additional safeguards. We urge the committee to carefully consider these recommended amendments.

We take this opportunity to bring one particular matter to the attention of the committee. The committee recently conducted an inquiry into the provision and regulation of supported accommodation in Queensland, tabling its final report in parliament on 7 June 2024. During that inquiry the use of restrictive practices on residents, in particular in residential services level 3 accreditation, was identified as a key concern among multiple stakeholders. The Public Advocate has also expressed concern that the extent to which restrictive practices are used in these settings is unknown and the appropriateness of their authorisation is unclear.

Currently, there is an unacceptable gap in authorisation processes that results in residential service providers only being required to report on and seek authorisation for use of restrictive practices in relation to residents who are NDIS participants. This means that residential service providers can use restrictive practices on residents who are not NDIS participants without needing to comply with Queensland's authorisation framework.

In the inquiry's final report, the committee noted the work being undertaken by the department of disability services with regard to the authorisation framework for restrictive practices—work that has culminated in this current bill. Indeed, on page 62 of the final report on the inquiry the committee encouraged the department to continue with this important work and to give due consideration to the use of restrictive practices in level 3 residential services. However, the current bill does not appear to address this issue. Neither the bill nor the explanatory memorandum mentions accredited residential service providers. This means that the current gap in authorisation processes will continue to exist and that a significant number of residents in supported accommodation facilities will continue to be at risk of and subjected to unauthorised and unregulated restrictive practices with no oversight and with no safeguards in place. Given that the Queensland government has committed to reforming the supported accommodation sector as well as to improving the authorisation framework for the use of restrictive practices, it would be a travesty for both of these inquiries to go by without this glaring gap in authorisation processes being addressed by either one of them. If not now, then when? Thank you.

CHAIR: Thank you for your opening statement. I will call the member for Burnett for the first question.

Mr BENNETT: You probably heard I asked our last witnesses a question about supported accommodation. I fully support it and I shake my head as well, but there are so many other services, including aged care, for people with a disability who could be captured. It is a complex thing to start

in the disability services area and expand it. Do you have statistics about the number of people in supported level 3 accommodation, because these are the ones with behavioural support plans? Is that your understanding as well?

Ms Wiggans: Some of them would be. There is a concern because there is no requirement for residential service providers that are not also NDIS service providers to go through any kind of formal authorisation processes.

Mr BENNETT: Are not the majority of NDIS providers now level 3s?

Ms Wiggans: Some are but not all, no. Some level 2 providers have downgraded.

Mr Veerabhadra: In addition to that, there are consumers who do not have access to, for example, the NDIS. In that situation they are not captured by that particular information, but there is still the enforcement of informal restrictive practices. For example, at a place the committee visited we can identify within that space certain individuals who have had restrictions placed upon them in the space they live in. If they were to live on a separate piece of property, they would not be allowed to come into the main area to assist with dinner because the owner-operator was worried about the way the person would behave with others. It is an informal practice that is being enforced, but at the end of the day it is still a restrictive practice. There are still actions taken against particular individuals that restrict their behaviour and their ability to be free within the space they occupy. There is no way that person has any form of recourse because they are not captured by the NDIS. They are still going through the process of getting that approval. Then the owner-operator is enforcing their own plan.

Mr BENNETT: Do clients generally have these behavioural support plans as a go-to regardless of where they live and what organisation they may be connected with?

Mr Veerabhadra: It is not a guarantee. There are certain situations where PBSPs can become part of a person's NDIS package. Obviously when people have restricted practices included within their PBSPs that has to go through the department, so there is an extra layer of protection there. Individuals who do not have restrictive practices necessarily can have access to PBSPs as well, but that has to be funded in some fashion and oftentimes they will rely on NDIS funding to do so.

CHAIR: Your submission recommends penalties for service providers that fail to adhere to positive behaviour support plans and the introduction of mandatory training. I note that the department speaks to the development of market-based providers in Queensland. Can you comment on the current shortage of suitably qualified service providers and the risk that poses for people with disability?

Mr Veerabhadra: It is not necessarily the shortage; it is more so a standardisation. The fact of the matter is that currently the department is the one that is responsible for creating PBSPs for individuals who might have restrictive practices in place. With the clients I currently have with restrictive practices in place who have PBSPs, even they are not able to get the care I would hope for as their advocate to ensure those restrictive practices are not being enforced inappropriately. For example, I have a client who, if there is certain identification of behaviour, is locked down for an automatic 48 hours, which means that for the first 24 hours they cannot leave that house. They cannot leave that particular space itself. After the first 24 hours they are allowed to go on site walks. They are allowed to go out, have a little walk, maybe go to the barbecue that is nearby and cook something up, but they can access their vehicle to then go further out into the community. That takes another 24 hours.

The problem with that is the PBSP does not actually identify that as the way to enforce seclusion or containment, but that is how it is being enforced. Right now the clinicians we have through the department do not have the ability to go and train individuals appropriately to respond to those situations appropriately. We have tried to raise concerns about this, but it is really hard. There are not a lot of resources available. There are not a lot of people who are well educated in this space to address those concerns. The idea to reach out to private providers is going to water down the system even further. I feel there is going to be a level of focus on providers more so than on the actual individuals themselves. Where is the incentive to then reduce and eliminate restrictive practices moving forward if there is going to be a business created around it and the production of PBSPs for restrictive practices?

Ms Wiggans: I would just reiterate the point that other witnesses have raised around the need to add in that accountability mechanism to this framework. We have made some suggestions for amendments around ensuring there is accountability for providers who are not following PBSPs and are not complying with conditions. There should be better data collection to see what trends are happening over time because the focus of the regime must be around working towards reducing and

eliminating the use of restrictive practices, not just complying with certain authorisation processes. It actually has to have that as its goal, so embedding in accountability will help move providers towards that goal.

CHAIR: You do not see any problems with that?

Ms Wiggans: In what way?

CHAIR: The comment you just made, moving towards those providers.

Ms Wiggans: I see the need to put in place as many things as we can to make sure that providers are incentivised to look at how they are reducing and eliminating the use of restrictive practices, not just complying with formal processes and things like that. We do not want to normalise the use of restrictive practices. Adding in those extra accountability measures will hopefully help steer them on the road where they need to be going, which is reducing and eliminating the use of restrictive practices.

Mr BERKMAN: Would you agree with previous submitters that there should be legal consequences or penalties not just for failing to adhere to PBSPs but also any unauthorised use of restrictive practices? Is the absence of penalties a problem in your eyes too?

Ms Wiggans: Absolutely, yes.

Mr Veerabhadra: When is the last time someone has been charged and convicted of deprivation of liberty in the role of a service provider? The current measures that are there really do not do much. Even the idea of a blanket immunity seems counterintuitive. We are here to protect people's rights. If someone is performing a job who comes along with a certain level of risk, they need to show how they have managed that risk well. The ownership should be on them as opposed to showing there is negligence or there is dishonesty. I would point to what Ms Leong said earlier. It becomes hard when your clientele have cognitive impairments to get statements to provide evidence in order to get that threshold for any type of criminal liability.

Mr BERKMAN: I also intended to ask about the positioning of prohibited restrictive practices in regulation rather than in legislation. Can you just elaborate for the committee why you see it as important that they be legislated rather than regulatory prohibited restrictive practices?

Ms Wiggans: I think it just adds greater weight behind it. It elevates the status of it. It was also recommended by the disability royal commission. As Ms Leong said, the royal commission recommendations have provided a list of practices that it believes should be prohibited, but within one of the recommendations—I cannot remember the number, but it is in my submission—it does mention that they should be in the legislation, so we support that.

Mr BERKMAN: Is there any potential upside to the flexibility that comes with having it as a regulatory list rather than a legislated one? Is it your view simply that it should be legislated?

Ms Wiggans: In our submission we noted that, if it was to be in the legislation, it should be specifically noted that it is not an exhaustive list and there could be other things that are not captured within that. We will stick with our position that it should be in the legislation just to give it that elevated status.

Mr BENNETT: In the submission there were some recommendations around changing some terminology from 'harm' to 'serious harm'. Can you explain why that is important?

Ms Wiggans: When decisions are being made about authorising restrictive practices—and the wording of the legislation is referred to frequently around that decision-making—there is a difference between if something is going to cause harm to a person as opposed to serious harm. It is a different threshold. Given the grave nature of many of these restrictive practices and the serious infringement on people's human rights, they should only ever really be used as a last-resort measure when there is no other alternative and other things have been tried. Increasing that threshold to serious risk of harm, which was the wording used in the disability royal commission—that is what is recommended in their report—helps to make sure it is only in that last-resort situation as opposed to just risk of harm, which is far broader and far more open to interpretation.

There were questions around the use of substances which could cause harm. That is the kind of thing that really opens it up. It is particularly concerning when there is still this very piecemeal coverage around the authorisation of restrictive practices, so they continue to be used in places which do not have the level of oversight they should have. I think the wording around 'harm' and 'serious harm' is quite important in terms of making sure that that threshold is as high as it should be.

Mr Veerabhadra: It is also consistent with other legislation that restricts rights, for example the Mental Health Act. For something as simple as a treatment authority you need to establish there is a serious risk of harm to the person or others. It is quite consistent with the fact that it is meant to be the least restrictive approach.

CHAIR: As there are no further questions, thank you for your time and presenting to the committee today.

ARMSTRONG, Ms Paige, Organisational Consultant, Queenslanders with Disability Network (via teleconference)

CASON, Ms Rebecca, Senior Policy Officer, Queenslanders with Disability Network

CHAIR: Welcome. Good afternoon. I invite you to make an opening statement before we start our questions.

Ms Cason: Thank you for the opportunity to be here today to speak to the Disability Services (Restrictive Practices) and Other Legislation Amendment Bill. I would firstly like to acknowledge the traditional owners of the unceded lands, the Turrbal and Yagara peoples, and pay respect to elders past, present and emerging and also to acknowledge the important role Aboriginal and Torres Strait Islander peoples play in community.

Queenslanders with Disability Network is an organisation of, for and with people with disability. QDN operates a statewide network of over 2,000 members and supporters who provide information, feedback and views based on their lived experience which inform our systemic advocacy work. QDN commends reform to the use of restrictive practices and we have provided a submission to the 2022 consultation paper. QDN was also engaged to run focus groups as part of that consultation process, and we are very pleased to see that the amendment bill aligns with feedback from these consultations. QDN supports the bill to deliver a high-quality system that includes a nationally consistent, user-friendly approach underpinned by a human rights framework, safeguarding people with disability.

The continued focus needs to be on the reduction and elimination of the use of restrictive practices and building the capacity of the workforce through training to deliver quality services and supports. QDN acknowledges the need for a more streamlined authorisation process for restrictive practices and the establishment of a system that has the Senior Practitioner to carry out the functions of authorisation. The Senior Practitioner must take a person-centred, human rights based and culturally safe approach to decision-making when authorising a restrictive practice.

QDN supports in principle the phased approach over a 20-month period for the development of positive behaviour support plans which are inclusive of containment and/or seclusion to be developed by specialist behaviour support practitioners in the open market. However, this needs to be reviewed at 12 and six months out to determine market capability to take on this role, and government needs to have a contingency plan around this. QDN also acknowledges the removal of the chief executive of disability services to decide whether a multidisciplinary assessment will be conducted in the circumstances of containment or seclusion. QDN supports the need for multidisciplinary assessments where required when conducting the functional behavioural assessment to ensure a holistic approach to meeting individual need. I would like to pass to Paige now to finish the opening statement.

Ms Armstrong: We also support the establishment of mechanisms that afford people a right of review of decisions around authorisation and that the bill stipulates QCAT have a responsibility for this function as a review body. We think this is key to accountability, and QDN members and supporters have raised a range of issues around decision-making and authorisations and believe that the reform process—the system that is developed—needs to ensure independence and adequate skills, monitoring and oversight that is transparent and easy to navigate. Our members and supporters have also highlighted the importance of communication with the person with disability and their families around the restrictive practice. We cannot stress how important this is. People need access to independent assessments around decision-making and, where needed, access to independent advocacy. A safeguarding framework must be in place that includes an inquiry process when a safeguarding concern is raised for the person in care who has died to identify and protect other people who may be experiencing or at risk of abuse or neglect, and the safeguarding framework must ensure learning and improvement in practice and be reviewed regularly. We also think that integration and application with other service systems is critical to ensure a smooth, streamlined and consistent approach.

Overall, our organisation cannot stress enough that core to achieving this and the other reforms outlined in this bill is the involvement of people with disability, their families and providers in the next stage of the reform to co-design implementation and transition and to ensure there is a clear engagement strategy so that the sector broadly is aware of the reforms taking place. There are a range of issues that accompany this reform, some of which we have started outlining above, that we think need to be considered in implementation and through the transition process, and we are more than happy to take questions regarding our submission or any of those issues. Thank you.

CHAIR: Thank you, Paige and Rebecca, for your opening statements.

Mr BENNETT: Before I ask my question, on behalf of my colleagues I pass on our thanks for QDN's work with the supported accommodation inquiry. You and the advocates gave up a lot of time and you have a lot of passion for the industry, so thank you. I am looking at Rebecca, but Paige made the comment about QCAT. In advocacy for that support network, is the principal practitioner, the Senior Practitioner, not a better option? I will not be critical of QCAT, but is it the best system we have to review and to provide advocacy on behalf of people with a disability or their families or, in some cases, providers?

Ms Cason: Paige, did you want to take that one around QCAT? In terms of advocacy for people with disability and the work that needs to be done there, we find that peer support works really well as well because those relationships are already established with people. Paige, you probably have more to add to that question.

Ms Armstrong: Thanks, Rebecca, and thanks to the member for Burnett. I am up in Townsville today revisiting a couple of those level 3s that the member for Burnett had the opportunity to visit with us only recently, giving some feedback to residents, owners and staff about the next stages of the parliamentary inquiry process around supported accommodation. To answer your question and to add to what Rebecca was saying, my understanding is that the chief practitioner will have a role in approving restrictive practices in Queensland and that there needs to be a separate mechanism that is able to look at a review of those decisions. The feedback that QDN gathered from our consultations was that QCAT would provide a suitable mechanism to do that that would not negate, but we are also saying that people with disability and their families who come under a restrictive practices and positive behaviour support regime should also have access to independent advocacy to support their individual situations or cases if they have issues with decisions that are being made and that they should be supported, whether that is supported with an application to QCAT or supported to have discussions around that plan before it gets to the more formal stage of a review.

Mr BENNETT: Did we find that the timeliness of the QCAT review is appropriate considering that concerns around restrictive practices may be, in some cases, quite serious or in breach of human rights or something else? Are we comfortable and are your members comfortable that that process is quick enough or appropriate enough for their wellbeing?

Ms Armstrong: Rebecca might like to add to this, but my understanding is that the other thing that our members are telling us and very much stressing is the need for a clear implementation process, and that implementation process needs to actually work through how these things would be operationalised and that there needs to be sufficient resources in place to enable very timely reviews by QCAT. Bec, unless I have it wrong, I suppose what members were saying to us is that, as good as the chief practitioner may be, they were wanting some separation between that role and the high decision-making power it had around adopting a restrictive practice and a body that was able to then look at that if a person with disability, their advocates or family were saying, 'We disagree with the position.'

Mr MARTIN: In relation to the QDN's submission, you note that the implementation and transition team would benefit from practical tools and resources. Could you elaborate for the committee on what practical tools and resources you are referring to?

Ms Cason: I think the biggest thing around implementation is really around the workforce development and building the capability of not only the providers but also all of their staff. There are a few things. There is the workforce development piece and the tools and resources with that. There is also the education and learning piece for providers and also for people with disability and their families. Those three pieces really do need to be co-designed with people with disability and their families so that people understand their rights and also how to protect themselves or how to ask for help. It is really going down to those very basic levels of people understanding what a restrictive practice is. I know that Paige will also have some input into this around providers understanding what a restrictive practice is. That learning piece is really important. Paige, did you want to add to that?

Ms Armstrong: The other thing I wanted to add, given that there is a change to the scope of this legislation, is it very importantly includes children and families who are getting supports through the NDIS. This is a significant change because this group has not necessarily been captured under the same range under this legislation and under previous similar legislation that is state based, from my understanding. From what members told us during the consultations, I think it is very important that people with disabilities and their families are also made fully aware of the changes that are taking place with this new piece of legislation coming in and what it will mean for them. As Bec is saying, it is not only the providers that need to understand what a restrictive practice is and what positive

behaviour support can achieve in improving a child's, a young person's or an older person's life outcomes but also family members and people with disability themselves who now may come under a restrictive practice or a positive behaviour support plan needing to understand the benefits for themselves or the broader community, and this is happening.

CHAIR: Before calling the member for Maiwar, I wanted to elaborate a little further on the comment made about the transition of the benefits of practical tools and resources. Given that we are a really decentralised state, workforce development must be a real consideration and, given the fact that Paige is in Townsville, it is probably appropriate at this time to talk about what impacts having such a decentralised state will have on workforce development for issues like this.

Ms Cason: In terms of those areas in particular where there are thin markets for NDIS providers, for people with disability and their families there are peer support and networks that could be used in those cases and resources developed so that they can talk to their peers. We have a very wide network of peer support groups throughout Queensland that could be activated to take on that education and learning piece for people with disability and their families. For the providers, where there are thin markets, Paige, do you have any ideas around resources in those areas?

Ms Armstrong: I would agree that is something that needs to be considered and implemented given we have such a decentralised state. In some of our regional and remote areas we are already seeing the impact of thin markets but, most importantly, the impact of the lack of ability to secure a range of allied health professionals. Having said that, QDN would be more than supportive of strategies as they roll out that work very closely with National Disability Services, the key service provider up here for disability services, Queensland Alliance for Mental Health organisations and other similar bodies, as well as some key community sector bodies such as the Queensland Council of Social Services in working through how best to implement this strategy to get the best use of current resources and how we might try to maximise appropriate human resources on the ground in rural and remote areas.

Mr BERKMAN: I wanted to check in with you about a couple of issues that other submitters have raised, the first of which is the absence of any penalty or consequences for noncompliance with the framework or with a particular authorisation. Would you consider there should be penalties or some direct consequence built into the bill?

Ms Cason: Yes, we would consider there should be consequences or penalties—I am not sure if that sits in the bill or in another area—as long as providers have received appropriate education as well around what a restrictive practice is. We have brought up level 3 supported accommodation providers before. In terms of accommodation, they are not NDIS providers but many of them have set up NDIS businesses. In the 22 facilities we visited, 76 per cent of residents were NDIS participants. It is clear there is not enough education for those providers around what a restrictive practice is. Paige, would you agree?

Ms Armstrong: I would agree there needs to be penalties. I think it needs to be measured by the fact that this piece of legislation now also captures a range of other state-based disability services that have not been providing services under the NDIS. They have not had the benefit of NDIS implementation around restrictive practices and positive behaviour support because organisations that are providing services under that funding mechanism for the last nearly 10 years have been required to undertake and deliver these services in a particular way. Expanding this will now include a range of state-based disability providers. Some that act as direct disability providers that have been around for a long time would have a better understanding. There will be a range of other providers where this will be very new to them. There will need to be a real scaling up of their awareness and understanding of how these things are applied practically on the ground for the benefit of people with disability and their families and not just taking the approach of heavier penalties.

Coming back to the question around our workforce capability, given the bill now expands to other state funded disability services we are at a time where we have a lot of expansion taking place around disability very quickly. Resources overall have been stretched. We want to make sure there are measures in place to build capacity whilst at the same time there are oversight mechanisms in place that are able to quickly identify those organisations that carry out poor practices and, most importantly, those practices that are putting people's safety and wellbeing at risk and that they could very quickly be stopped from doing that.

Mr BERKMAN: One other issue from other submitters I wanted to put to you is the suggestion that there should be a less prescriptive and more discretionary ground for cancelling an authorisation than what is provided for in the bill as it stands. Do you have a view on whether there should be a broader discretion for the cancellation of authorisations?

Ms Cason: Yes, we would agree with other submitters on that.

Ms Armstrong: I agree completely.

CHAIR: With that, our time has expired. I want to thank both Rebecca and Paige for your time and presenting to this committee.

ROWE, Mr Geoff, Chief Executive Officer, Aged and Disability Advocacy Australia

WILLIAMS, Ms Karen, Principal Solicitor, Aged and Disability Advocacy Australia

CHAIR: I now welcome representatives from Aged and Disability Advocacy Australia. Would you like to make an opening statement before we start our questions?

Mr Rowe: Thank you for the opportunity to speak with the committee this afternoon. I would like to acknowledge the traditional owners of the land on which we meet and pay my respects to elders past, present and emerging. I will take our submission as read. You will see from our submission that Aged and Disability Australia, ADA, generally supports the proposed legislative amendments. What is ADA and why do we have an opinion? ADA is an organisation that has been working in Queensland for the last 30-plus years, primarily providing human rights based services to older people and people with a disability. We employ about 120 staff across the state. We have a footprint that takes us from the Torres Strait to the border and staff are located right across the state. We provide disability advocacy to users of Commonwealth funded aged-care services. We host the Aboriginal and Torres Strait Islander Disability Network of Queensland and they deliver our First Nations disability advocacy service. We also operate Care Finder services, an initiative that came out of the aged-care royal commission, which support the most vulnerable people in the community—people who are homeless, people who have literacy and mental health issues, people who do not normally access services. Our footprint there is largely in regional, Western and North Queensland.

We also operate a number of community legal services trading as ADA Law and Karen is our principal solicitor. We support people whose decision-making is being questioned through the QCAT process. Karen probably spends half her life at QCAT. She should probably be on the payroll there, but thus far we have not managed to crack that one. We also operate a Seniors Legal and Support Service which targets Outback Queensland, which is a very vague definition, but it is not in the major populated areas. Finally, we operate a mental health legal service in Townsville. We have a reasonable footprint. I do not have the stats for the last year, but generally we support about 10,000 people a year across the state. We are a small organisation but we have a reasonable size impact.

When I was thinking about my opening comments today, having been in the human services for a very long time I remember when the legislation for regulating the use of restrictive practices in disability was first implemented in Queensland. I think I am going back about 16 years on that. I took up a role at Endeavour Foundation at the time which was probably then the largest provider of disability services. Endeavour chose at that time to look at how they were delivering the services and how many people were impacted by the use of restrictive practices. At that stage we identified more than 750 people for whom the way we were supporting them was in breach of the new legislation. We had two options: one was to get 750 positive behaviour support plans together; the other was to see if we could eliminate the use of restrictive practices. That was where we started. Ultimately, we removed the use of restrictive practices for almost 650 of those 750-plus people. I have firsthand experience that, if you put your mind to it, rather than seeking to get approval for the use you can actually educate staff, look at people's medication, look at practices and building design et cetera to limit the use of restrictive practices. That is a good outcome for the individual and it tends to be a good outcome for the staff and the organisation as well. It can be done and it must be done. We must not see this as a mechanism that condones the use of restrictive practices. Indeed, it reinforces that the use of restrictive practices should be the last resort, not the first resort. I might leave it there.

CHAIR: Thank you for your opening statement. With regard to your advocacy for the aged, what is your demographic? Is it from 60 upwards or 55 upwards? What would you consider aged?

Mr Rowe: That is a personal question, isn't it? I suppose we are funded by the Commonwealth government to support users of the aged-care system, so not just people who are in residential aged care but people who get support in their home. We also know there are a number of people with a disability who are not necessarily aged but do find themselves in residential care because of the lack of options. The Commonwealth guidelines talk about people being over the age of 65, but for Indigenous Australians that is over the age of 50.

Mr BENNETT: If I may direct my question to Karen, I think you were here when I was talking about QCAT previously as an option. I think I was being critical, but my intention was to try and flush out information. I have a similar question. Unless we have representation from people like yourself or your organisation, is QCAT seriously the best organisation or the best place to provide balance to these vulnerable Queenslanders?

Ms Williams: The difficulty that QCAT finds itself in is that increasingly guardianship administration seems to be the answer for all difficult social and legal issues. Particularly as the population ages or people are more aware of their own disability or disability of people and their families, it is used increasingly to resolve a whole lot of issues. QCAT is just the tribunal; you have the registry, the Office of the Public Guardian and the Public Trustee. You have this ecosystem, but we have not seen the system as a whole terribly much. We just look at funding more QCAT, but the legal advocacy space has not caught up and so on and so forth.

The best answer is that, if it was QCAT, it would have to be a specialised program within the tribunal. You have the Mental Health Review Tribunal, which I am not proposing, but for some reason that was left out of folding into QCAT. You can look at mechanisms away from these big complex systems, even though there is a lot of expertise that resides in QCAT. It is difficult.

Mr Rowe: Do you want to talk a little bit about some of the work that Karen's team does in supporting people through QCAT around how do you access the existing supports that someone may have so that they do not get dragged into that system?

Ms Williams: Sometimes the tribunal will recognise a person's unique set of vulnerabilities and will be asked by QCAT, as they would ask other organisations, to take on the role of being a separate representative et cetera. That role involves extra workload for which there is no actual funding source. Legal Aid do not fund adults in that role. We actually quite enjoy that work because we are able to represent the views and wishes of the person, but it is an order of the tribunal that enables us to go and investigate who is out there.

Maybe the support network just needs a bit more education to say, 'This power of attorney means you can do that,' or 'How about you guys work together?' to try to minimise the issues that go before QCAT and we can make recommendations to the tribunal. So instead of the tribunal just going in, they have our written submission so they can see that they tried to work with the support network, upskill, involve professionals: 'Hey, have you thought about a referral to a geriatrician or a psychiatrist? Have you involved whoever it is,' because it is all different. That role is quite useful to the tribunal in trying to put a more complete picture of the person in front of them.

Mr BENNETT: What sort of time does it take between the hearing and the judgments when you take somebody with a disability issue through that process?

Ms Williams: Starting from scratch, it is so variable. If there is an interim order, it is mandatory within three months, but that is in a full-on urgent situation. If you fall outside of that scope, it is several months. Issues as complex as this with a potentially severe impact on the individual concerned could not sit in that slower stream. QCAT put a triage focus on their services as of roughly October-November last year.

Mr MARTIN: Geoff, I was very interested in your opening statement when you mentioned you used to work for Endeavour and you went through a process of reducing restrictive practices. I think you mentioned they managed to get them down from 700 to 100.

Mr Rowe: Give or take. It was about 750 or 760 down to 105.

Mr MARTIN: That is a massive reduction. Could you elaborate on that process for the committee? How did you manage where maybe there were situations of managers or staff or family who were keen to keep the restrictive practice in place but the leaders at Endeavour thought this should not be happening? How was that dealt with?

Mr Rowe: It is a bit of a distant memory. In broad terms it was about educating people—educating our staff, educating families—and demonstrating that there were other options. Having listened to some of the questions earlier about the role of advocates—and I was not there as an advocate in Endeavour—one of the things advocates try to do is talk to the individual and understand what their needs are, because families and the individual with a disability will not always be on the same page. We had a small positive behaviour support team that we were large enough to be able to engage. They were professionals—psychologists, OTs, physios and a range of people who had the skills to look at how we were delivering the services and to work with our staff, work with the individual, work with their families to facilitate that change. From memory, that was probably a two-year process. It was not magic, but it was sustainable.

For some of it, it was around chemical restraint being alive and well. I do not know how alive and well it currently is within the disability sector, but in the aged-care sector it is absolutely alive and well. We did a project with Human Rights Watch New York in 2018-19. They produced a report of the

findings. It really is quite concerning. The default is to use medication that will bring things under control. It was also a matter of getting some of the medical profession on side to be prepared to do a review and to look at things differently.

Mr MARTIN: Do you think then, based on the introduction of the previous legislation 11 or 12 years ago, that that has probably dealt with a large number of restrictive practices issues and that this legislation will deal with the next set of more difficult issues or more tricky ones?

Mr Rowe: Yes, the tricky ones—to use the technical term. I would like to think that is the case. I would like to think that because of the turnover of staff that you get within the care industries some of that corporate memory is lost. Again, it is very easy to default to a restrictive practice because it makes life easier for the worker. Unless the organisation continues or someone is continuing to drive the change, I think often the default is, 'Let's go back to what is the easiest, what is the quickest. We're all under the pump trying to get things done.'

I think the benefit of this is that it builds on what we had. I remember the lead practitioner who used to be around, again, 10-plus years ago, and that worked. How many people are like me and are still around the sector 10 or 15 years later, I am not quite sure. I am not on the ground—far from it. I do not really want to bring aged care into this, but it is an issue we are grappling with within aged care. Again, with the increased incidents of dementia, with cognitive decline and the growth in the aging population, there is more pressure on aged-care staff to get things done, and they end up doing things to people rather than with people.

Disability has always had a strong human rights basis. When the legislation came in in 1986 nationally and then in 1991 in Queensland, it was rights based. There has always been that little voice in the back that says, 'We should be doing the right thing for people, not the easier thing for us.' The short answer is that we are in a lot better space than we were. Are we there yet? If we were there, we would not be looking at this legislative change.

Mr BERKMAN: I want to touch on one point in your submission where you have raised concerns about amendments that prevent an individual from being held criminally or civilly liable for using restrictive practices, if they do so honestly and without any negligence. The term you used was that that effectively provides a blanket immunity that should be removed. Can you elaborate on your concerns there?

Mr Rowe: I have to say I am fascinated. I am watching this debate at the moment where the aged-care royal commission's first three recommendations were about introducing a new aged-care act and one that is based in human rights. There are no human rights. There is no mention of human rights in the current aged-care legislation. We are hearing aged-care providers saying, 'We're going to go broke if we start providing a rights-based service to people,' as though it means everyone is going to have a gold-plated toilet installed in their room. Rights are about how people are treated. Rights are about how people are engaged.

What is the difference between today when I am living at home and tomorrow when I am moved to aged care? Why should I be treated so differently? Why should there not be penalties associated with people's failures to deliver on those rights? I have been trying to think of a good analogy. As an employer I have to provide a safe workplace for my staff. Why should I be immune from making sure that my staff deliver safe services to people? It makes no sense. Most staff drive to work. They have to go through a licensing process. If they do something that is absolutely reckless—if they drive in drunk and have an accident—there are penalties associated with that. If the brakes fail on their car for no good reason, there is that step back in terms of liability. I think that is all we are really asking for—that there are consequences for actions, not that they are heavy-handed.

One of the things we are talking about in the aged-care sector is that if it is so terrifying for people let us phase in some of those penalties. We could choose to do that here. Again, we are not talking about something that is new to the disability industry, although, as you have covered, we are talking about new players in the industry, so maybe they need time to learn. They should be proportionate. People die receiving services in the disability sector. We see some of it in the media. Some of it we do not see. Surely we all have a right to be safe if we are under someone's care and they are being paid to do that.

Ms Williams: The bottom line, however it is worded in the legislation, is that it is something that people look to straight up. It has a really important message about driving that cultural change that Geoff is talking about. You could have all of the other positive wording around things, but, if there are immunity provisions and the like, that is what people look at and think, 'Well, you are not serious.' That is part of the driving of change.

Mr BERKMAN: It seems to follow from what you are saying, although it is a slightly different question other submitters have raised, that there should be some penalties or legal consequence for noncompliance with authorisations. Is it the case that you would agree with that position?

Ms Williams: Yes.

Mr Rowe: Yes.

CHAIR: With that, I would like to thank you both for attending here on a Friday afternoon to provide evidence to the hearing today.

Ms Williams: Thank you for the opportunity.

CHAIR: Thank you for your submission. It was well written and well received. I really appreciate the work you are doing in this space. With that, that concludes today's hearing. I want to thank everybody who has participated today.

The committee adjourned at 3.42 pm.