COMMUNITY SUPPORT AND SERVICES COMMITTEE

Members present:
Mr A Tantari MP—Chair
Mr JP Lister MP (via teleconference)
Mr MC Berkman MP
Ms CL Lui MP (via teleconference)
Dr MA Robinson MP (via teleconference)
Mr RCJ Skelton MP

Staff present:
Ms L Pretty—Committee Secretary
Dr K Kowol—Assistant Committee Secretary

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

TRANSCRIPT OF PROCEEDINGS

Tuesday, 9 July 2024

Brisbane

TUESDAY, 9 JULY 2024

The committee met at 11.01 am.

CHAIR: Good morning. I declare open this public briefing for the committee's inquiry into the Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2024. My name is Adrian Tantari. I am the 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 very fortunate to live in a country with two of the oldest living 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 Michael Berkman MP, member for Maiwar, and Mr Rob Skelton MP, member for Nicklin. The members appearing via teleconference are Ms Cynthia Lui MP, member for Cook; Dr Mark Robinson MP, member for Oodgeroo; and Mr James Lister MP, member for Southern Downs, who is substituting for Mr Stephen Bennett MP, member for Burnett.

This briefing 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 briefing 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. To assist the committee, I ask that you please turn your mobile phones off or to silent mode.

MANWARING, Ms Amber, Director, Strategic Policy and Legislation, Department of Child Safety, Seniors and Disability Services

ROWE, Ms Elizabeth, Acting Executive Director, Strategic Policy and Legislation, Department of Child Safety, Seniors and Disability Services

TUBOLEC, Ms Melinda, Principal Legal Officer, Strategic Policy and Legislation, Department of Justice and Attorney-General

CHAIR: Good morning. Ms Rowe, as acting executive director, I invite you to make an opening statement before we start our questions.

Ms Rowe: Good morning. I also begin by acknowledging the traditional owners of the land on which we meet today and pay my respects to elders past and present. I would also like to extend that respect to any Aboriginal or Torres Strait Islander people joining us today. I also want to acknowledge the lived experience of people with a disability, their family members, carers and supporters. I want to recognise the significant contribution the disability community has made to the development of the bill we are discussing today.

Thank you for the opportunity to brief you today on the Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2024. The bill proposes to reform the authorisation process for restrictive practices used by relevant service providers in disability support settings. The bill also seeks to expand the reportable deaths in care framework under the Coroners Act for people who receive disability supports under the Commonwealth government's Disability Support for Older Australians program.

I will start by providing some brief background on the bill. A restrictive practice is any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with a disability. Restrictive practices are used to respond to the behaviour of a person with a disability that causes harm to the person or others. This can include physical, environmental, chemical or mechanical restraints, or seclusion. Restrictive practices can fundamentally impact the human rights of an individual and can include actions that, without lawful justification, may attract civil or criminal liability. Because of this, it is critical that strong safeguards are in place to regulate restrictive practices

so that they are only used as a last resort. Authorisation of restrictive practices gives service providers a lawful basis to use a restrictive practice when required and it ensures the restrictive practice is the least restrictive way of ensuring the safety of the person or others.

Queensland's current framework has been in place since 2008. It currently only applies to restrictive practices used in specialist disability support settings in relation to adults with an intellectual or cognitive disability. Currently, service providers must ensure an assessment of the person with the disability has been undertaken; prepare a positive behaviour support plan, respite or community access plan for the person; and seek approval or consent to use the restrictive practice. Currently, authorisation processes differ widely depending on the type of restrictive practice, the setting it will be used in and the proposed term of the authorisation.

Since 2019, the NDIS Quality and Safeguards Commissioner has been responsible for monitoring the use of restrictive practices. States and territories are responsible for the legislative and policy frameworks for authorising the use of restrictive practices. In 2020, disability reform ministers agreed to principles for nationally consistent authorisation processes. Queensland's current framework does not align with these national principles. It is inconsistent and, at times, duplicates requirements under the NDIS (Restrictive Practices and Behaviour Support) Rules 2018.

To respond to these issues and the complexity of the current framework, a review was undertaken to consider the policy, financial and legislative implications of reforming Queensland's authorisation framework. The reformed framework has been tested with the disability community throughout this review. The bill establishes the role of the Senior Practitioner and the Office of the Senior Practitioner to provide clinically-based authorisation decisions for restrictive practices. This streamlines authorisation processes and reduces complexity and regulatory burden for service providers. The Senior Practitioner may only authorise the use of restrictive practices in line with a set of clear criteria which aim to uphold the human rights of the person with a disability. This includes that the restrictive practice must be the least restrictive way of ensuring the safety of the person or others. Further, a new merits review jurisdiction for QCAT will mean all authorisation decisions in Queensland will be reviewable.

While the current framework only applies to restrictive practices used in relation to adults with an intellectual or cognitive disability, the bill broadens it to apply to all adults and children while receiving NDIS supports or services or disability services. The proposed framework will apply to all forms of regulated restrictive practices under the Commonwealth's NDIS rules. The bill will remove the current requirement for the chief executive of Disability Services to develop all behaviour support plans that include containment and seclusion to allow specialist behaviour support providers to develop these plans, consistent with the NDIS rules. It is intended a phased approach based on market capacity will be undertaken and over time the Queensland government will no longer prepare these plans.

Finally, the bill also amends the Coroners Act to expand the reportable deaths in care framework to reinstate coverage for persons who receive disability supports under the Commonwealth government's Disability Support for Older Australians program. This is consistent with the scope of the reportable deaths framework that applied before the transition to the NDIS. Thank you.

CHAIR: Thank you, Ms Rowe.

Mr BERKMAN: Thanks for the opening statement and for being with us this morning. The explanatory notes to the bill use the term that this bill sees Queensland move towards the principles for nationally consistent restrictive practices authorisation processes. As I understand it, all other states and territories have agreed to the national principles in full, so my question really is: will this bill bring Queensland completely into alignment with the national principles and, if not, in what respects will we not be in alignment with those?

Ms Rowe: Yes, this bill does bring us into full alignment with the national principles, similar to the other jurisdictions.

Mr BERKMAN: Great.

CHAIR: The next question is from the member for Southern Downs, who is on the line.

Mr LISTER: Chair, you can hear me okay?

CHAIR: Absolutely.

Mr LISTER: Good. Thank you very much to the officers who have come to brief us today. I just wanted to ask about behaviour support plans. If somebody with a disability is on an NDIS behaviour support plan and if there is an unauthorised use of a restrictive practice that has to be reported, what will be the requirement for those who are on an equivalent to the state behaviour support plan? Will there be a similar requirement to report that to the NDIS Quality and Safeguards Commission?

Ms Rowe: We have aligned in the bill the behaviour support requirements required under the NDIS rules for state behaviour support planning. Because they are state providers and clients, they will not be required to report to the commission. However, they will be required to report to the Senior Practitioner.

Ms Manwaring: Yes, and the chief executive—

Mr LISTER: Thank you for that.

CHAIR: Was there a further comment to that?

Ms Manwaring: Yes, and the chief executive of the Department of Child Safety, Seniors and Disability Services.

CHAIR: If you want to make further comment, that is fine.

Ms Manwaring: No, that was all I wanted to add. Thank you.

CHAIR: Member for Cook, do you have a question? No? Okay. One of the bill's stated objectives is to promote the reduction and elimination of the use of restrictive practices. Does this imply that, longer term, the complete elimination of restrictive practices is a goal and, if so, what further strategies are planned to achieve this?

Ms Rowe: Yes. Ultimately, one of the functions of the Senior Practitioner is to drive the reduction and elimination of restrictive practices through their authorisation function. Our framework works to complement the NDIS roles and responsibilities, so ultimately the NDIS commission as well as the Senior Practitioner have the primary responsibility for driving the reduction and elimination of restrictive practices. They do that through their positive behaviour support planning function as well as monitoring the use of restrictive practices.

CHAIR: Member for Oodgeroo, do you have a question? No? We will try the member for Cook again.

Ms LUI: Yes. Can you hear me, Chair?

CHAIR: Yes, I can.

Ms LUI: Good; thank you, Chair. One of the bill's stated objectives is to promote the reduction and elimination of the use of restrictive practices. Does this imply that, longer term, the complete elimination of restrictive practices is the goal and, if so, what further strategies are planned to achieve this?

Ms Rowe: Yes, that is correct. I think we just had this question from the other member, but that is right. One of the primary functions of the Senior Practitioner is to drive the reduction and elimination of restrictive practices, and they will do that through their authorisation function. More broadly, this bill complements the roles and function of the NDIS Quality and Safeguards Commission. They also have the function to drive the reduction and elimination of restrictive practices and they do that through a number of ways including positive behaviour support planning functions and monitoring the use of regulated restrictive practices.

CHAIR: Do you have a further comment?

Ms Manwaring: Yes. The Senior Practitioner's main function is to drive reduction and elimination and the Senior Practitioner will do this through a number of its roles and responsibilities in Queensland, so that will include publishing data about restrictive practice authorisations; monitoring and receiving complaints about the compliance of service providers with the authorisation framework for the use of regulated restrictive practices; developing and providing information, education and advice about regulated restrictive practices; and developing guidelines to support service providers in relation to those applications for authorisation. These are intended to continue to drive the reduction and elimination.

Dr ROBINSON: If someone has touched on this already and it has been covered to some degree, I am happy to ask something else. In terms of the complaints and monitoring function, has the size of the team, the functions and the resources needed to police that been covered?

CHAIR: No, it has not.

Dr ROBINSON: That is my question. Could you address that, please?

Ms Rowe: In the reformed framework, the Senior Practitioner will have a complaints and monitoring function. Amber, did you want to elaborate?

Ms Manwaring: The monitoring and complaints mechanisms for the use of restrictive practice sit within the role and responsibility of the NDIS commissioner. The NDIS commission regulates and oversights the use of restrictive practices. The commission has those compliance and enforcement powers.

Ms Rowe: The Senior Practitioner will be able to receive complaints as it relates to their authorisation function. Once they receive that information, they will be able to pass it on to the NDIS Quality and Safeguards Commission. As you can imagine, the commission has a function and our state has a function, so we can share information as required in that respect. Does that answer the question?

Dr ROBINSON: Yes, it does in part. If I have missed this, please excuse me: what of the size of the team and the resourcing to police it?

Ms Rowe: Ultimately, the size and the structure of the Senior Practitioner's office will be a matter for the Senior Practitioner. That is an implementation decision. Government has provided increased funding of $12.4 million over four years to meet the increased demand of the current framework and it has also committed to $20.1 million for implementation.

CHAIR: Does that answer your question, member for Oodgeroo?

Dr ROBINSON: Yes. With your indulgence, Chair, could we have a little bit more of an understanding of that $12.4 million and $20.1 million, and the particular elements to those expenses?

CHAIR: Would you like to take that on notice?

Ms Rowe: Yes. We can provide more information about that.

CHAIR: Member for Oodgeroo, the question is taken on notice and we will get that information back to you.

Dr ROBINSON: Great, thank you.

Mr BERKMAN: I am interested in how the annual reviews of the comprehensive behaviour support plans will be administered and the level of detail that they will engage with. For example, will they be as detailed as an initial application or is there a lesser threshold or detailed analysis?

Ms Manwaring: In terms of the annual reviews and the process that will be undertaken, it will be for the Senior Practitioner to determine how they are done, obviously in line with the authorisation criteria that has been provided for in the bill. The Senior Practitioner does not necessarily review the behaviour support plans; it will be reviewing the authorisation decision. Behaviour support plans are monitored and oversighted by the NDIS commission. The function of the Senior Practitioner is to really consider if the authorisation continues to be appropriate, using the behaviour support plan that has been provided by a service provider.

Mr BERKMAN: I think I am clear on that.

CHAIR: I note from your briefing paper that one of the key features of the bill includes the fact that you will remove the requirement for the chief executive officer of Disability Services to prepare all BSPs that include containment or seclusion. This will allow those plans to be prepared by market-based providers. What conditions will apply or be set for those market-based providers in producing those BSPs?

Ms Rowe: The standard for behaviour support planning is the responsibility of the NDIS commission. The bill does not set standards for that. It is really a matter for the NDIS Quality and Safeguards Commission.

CHAIR: Will there be a standard template for something like that, if a market-based provider was to produce that?

Ms Rowe: I do not know specifically, but I can imagine it is. The commission sets all of the standards for behaviour support planning and it has a lot of guidance material through legislative mechanisms as well as policies and procedures. We can provide some more information for you, if that would be helpful, around behaviour support planning.

CHAIR: Can you take that on notice?

Ms Rowe: Yes.

CHAIR: It would be good to see what is provided to those market-based providers. Does any member online want to ask a question?

Dr ROBINSON: Chair, has there been discussion yet on section 190 of the Disability Services Act?

CHAIR: No, there has not.

Dr ROBINSON: Can we get some more context around the issue of immunity for individuals in terms of being criminally or civilly liable or otherwise for using a regulated restrictive practice if they have acted honestly and without negligence? Can you talk us through the need for that provision, how that works and some of the context around immunity? Perhaps it is a little complex in law, but can you give us a better understanding of how that will work in practice?

Ms Rowe: This is currently how the restrictive practice authorisation framework works in Queensland. Because of the seriousness of restrictive practices and the implications they have for the human rights of people with a disability, without lawful justification they may attract civil and criminal offences. We have carried over the immunity provisions into the new bill. If they do not follow the authorisation process then they are liable under the Criminal Code or civil law. With serious assault, for example, if they are not following the authorisation process then that is where the consequences lie. We are not duplicating in our framework the civil and criminal liability that currently exists under the Criminal Code.

I will add that the broader requirements around enforcement and compliance are the Commonwealth's responsibility. They have enforcement powers for registered NDIS providers and their workers. They can take a range of actions in this space if providers breach their registration requirements around behaviour support planning and restrictive practices. That can include civil penalties or banning orders and things like that.

CHAIR: Does that answer your question, member for Oodgeroo?

Dr ROBINSON: Yes, thank you.

Mr BERKMAN: The fact that all authorisation decisions are reviewable before QCAT potentially opens up a pretty substantial area of practice and need for legal supports for people the subject of those authorisation decisions. Does the department plan to make provision for additional legal supports or resourcing for anyone who is the subject of an authorisation decision? Will they have access to legal supports and to what extent?

Ms Rowe: I will ask Melinda to speak to this a little as well. The bill does provide a range of safeguards to protect the rights and interests of people with a disability. It is not a requirement but it does enable representation through the merits review processes. Did you want to add any more?

Ms Tubolec: The bill does not provide a right to representation, as Liz just mentioned, but it does provide a framework for QCAT to be able to appoint representatives for adults who are subjected to restrictive practices and for children. The provisions in the bill operate in addition to existing provisions in the QCAT Act. Section 43 of the QCAT Act provides an automatic right to representation for children and adults with impaired capacity. That law already exists and the provisions in the bill build upon that.

You can see that the provisions in the bill have some very nuanced provisions for representation for children. They are drawn from the Child Protection Act framework. The bill provides an ability for QCAT to appoint a separate representative for a child. That is not a normal lawyer-client relationship. A separate representative does not act on the instructions of a child. They are there to represent the best interests of the child and to make sure those best interests are communicated and made known to the tribunal.

Similarly, consistent with an existing representation option in the guardianship framework for adults with impaired capacity, the bill allows an equivalent type of representative but in an adult context to be appointed. The language is slightly different because when we are dealing with adults with impaired capacity the representative is there to seek and find the adult's views, wishes and preferences and to make those known to the tribunal as well. It allows those two slightly modified types of representation to be there where there may not be a capacity to instruct a lawyer in the traditional lawyer-client sense. That framework is built basically to model the Child Protection Act for children and modelled on the guardianship act provisions. I think section 125 of the guardianship act has a similar appointment provision at present under the current framework as well.

Mr BERKMAN: That is all very helpful, thank you. There is a lot of detail in that. Separate from what is allowed and what is provided for in the act, obviously these folks are going to be very much dependent on whether it is legal representation or non-legal advocacy in a lot of circumstances. We have heard from some of the key disability advocates that they think there should be an entitlement to automatic legal representation without cost and without means testing. Is that something that is being considered or actively worked on within the department, to your knowledge?

Ms Rowe: It is not currently funded explicitly for legal advocacy services. However, people who require assistance and meet the means test for Legal Aid Queensland can apply through Legal Aid Queensland. We have a long lead time for implementation and it will be part of the consideration of that implementation. As the Office of the Senior Practitioner is established, we are going to monitor the demand and the requirements for that legal advocacy as part of that process to see if any additional resourcing is needed in that context.

Mr BERKMAN: I assume that will consider the community legal sector?

Ms Rowe: Correct.

CHAIR: Do any members online want to ask a question?

Ms LUI: I refer to the University of Melbourne report titled *Restrictive practices: a pathway to elimination*, which was commissioned by the disability royal commission. The report was critical of the use of restrictive practices and stated—

> Restrictive practices are legally authorised and/or socially and professionally sanctioned violence that targets people with disability on a discriminatory basis and are at odds with the human rights of people with disability.

The report found that such practices are at odds with international human rights obligations and they strip people with disability of dignity. What are your views on these findings and recommendations? Did the department evaluate whether the use of restrictive practices is discriminatory?

Ms Rowe: In the context of the disability royal commission, the Queensland government has not provided a response to the disability royal commission. That is a policy matter for government. However, I will say that we definitely agree that the restrictive practices can present serious limitations on human rights of people with a disability, and the framework has been designed so that restrictive practices are only used as a last resort. The bill has been assessed as compatible with Queensland's Human Rights Act. In that context, the bill seeks to balance any limitation of those human rights with the purpose of protecting the safety of a person with a disability as well as others. It does this by ensuring restrictive practices are only authorised if they are the least restrictive option, are a last resort and supported by robust positive behaviour support planning, and support the person to use alternative strategies that will promote the reduction and elimination of the use of restrictive practices over time.

CHAIR: Proposed section 175 of the Disability Services Act sets out that a state behaviour support plan can be developed by a behaviour support practitioner, and this goes a little bit towards my last question regarding the market-based providers. This is defined as a person who has qualifications and experience to conduct a behaviour support assessment and to develop a behaviour support plan for a person with a disability. The bill includes a list of people who may have appropriate qualifications. Given this is a non-exhaustive list, how are suitable qualifications and experience to be formally determined?

Ms Rowe: The bill, as you say, only prescribes a certain list and does not necessarily go to the requirements. Ultimately, it will be an implementation issue, but the Senior Practitioner can issue guidelines, for example, which could include something in this scope. You are right: the bill is not very prescriptive, but the Senior Practitioner has the ability to set standards in that regard.

Ms Manwaring: I will say that the bill has been created so that the requirements for state-based behaviour support plans being developed align with the NDIS rules. While they sit separate to the NDIS rules, we have created in this bill consistency with everything that is in the NDIS rules so that their roles and responsibilities or the qualifications of behaviour support specialists doing those behaviour support plans will be set against the behaviour support rules. The Senior Practitioner is to rely on those when setting those standards.

Mr BERKMAN: Treat me like I am stupid: I am seeking clarification. When we are talking about state-based behaviour support plans and NDIS behaviour support plans, I am a bit confused about how they relate to each other and the role of the NDIS Quality and Safeguards Commission in oversight of those. Is it the case that the NDIS Quality and Safeguards Commission has—I think you said before—primary responsibility for oversight of all behaviour support plans, or is that only the NDIS?

Ms Rowe: Correct. Thank you for the opportunity to clarify it. It is only related to NDIS participants and NDIS providers. This bill sets the framework for behaviour support planning for state disability services and people with a disability. Wherever possible, because of the Commonwealth regulation, we have attempted to align to ensure the simplest outcome and that it does not duplicate. Because providers often play in both spaces, we have tried to mirror, as far as practicable, the Commonwealth requirements for planning within this bill.

Mr BERKMAN: That makes a lot of sense and dispels my misunderstandings, thank you.

CHAIR: With regard to QCAT's new role, I noted within your briefing paper that you state that the reformed authorisation framework changes QCAT's jurisdiction from an original jurisdiction to a review jurisdiction for authorised decisions. Can you give the committee a little bit more information about what that entails and what that means?

Ms Tubolec: Currently QCAT has an original jurisdiction, as you just mentioned, in this framework. What that means is that it makes original decisions to approve the use of containment and seclusion for adults with impaired capacity. That is slightly different to the role that it plays in relation to the other types of restrictive practices. In other types of restrictive practices, other than actually approving it, QCAT hears a proceeding to appoint a specially appointed guardian, called a restrictive practices guardian, to consent to the use of that type of restrictive practice. QCAT wears two hats in that space. Going forward, they will wear only one hat. They will have a merits review jurisdiction to conduct an administrative review of all authorisation decisions of the Senior Practitioner's office. Technically, the bill calls them part 6 reviewable decisions. There are certain sections that are defined as a part 6 reviewable decision, and that is where QCAT will look at the matter afresh and they will decide what is the correct and preferable decision that the Senior Practitioner ought to have made, with QCAT wearing that hat.

The merits review jurisdiction for QCAT is mostly governed by the QCAT Act, because it has 300 to 400 enabling acts that it does this type of work in. All of the provisions that regulate exactly how QCAT will conduct its proceedings and so on are set out in the QCAT Act, and then they are supplemented by the provisions in the bill to say how we are able to create a unique jurisdiction for QCAT, because it is not just your bread-and-butter review jurisdiction; this is a very highly vulnerable cohort. That is why we have imported a lot of the safeguards that currently exist in the guardianship act and merged it into a unique merits review jurisdiction with a lot of protections in them.

Generally, QCAT will hold a hearing to decide what is the best decision that should be made. The provision provides a lot of scope to allow lots of people who are involved in the adult's or the child's life to become a party to the proceeding, and that is deliberately designed to support the rights of adults and children. It is highly likely that the people who are subjected to restrictive practices will not be able to exercise those legal rights themselves, so they are highly reliant on their support network to exercise those rights for them. That is why the provision provides standing to a large number of people to actually bring forth that review application themselves.

The bill also allows a large number of people to be joined as a party. Even if they were not the original applicant and they have somehow heard about the proposed use of restrictive practice through their involvement in the adult's or child's life, they can later become a party to the proceeding, and that means they can give their voice to the tribunal to influence and make sure the tribunal is in the best place to make the most informed decision. The provisions allow them up to 60 days after the initial application is lodged or after receiving a notice of application to just opt in to be a party. If they miss the boat, that is okay: QCAT can still add them in at any time, right up until the final matter is determined. It is a very flexible process, trying to make it as protective as possible for the people who have been subjected to restrictive practices.

Mr BERKMAN: Turning back to that University of Melbourne report that the member for Cook referred to earlier—the disability royal commission—I am interested in whether or not, considering again broadly our international human rights obligations and OPCAT as one of that suite of obligations, there is a reason that the human rights principle in clause 18 does not include the right to freedom from torture, cruel, inhuman or degrading treatment or punishment, in line with OPCAT obligations.

Ms Rowe: Ultimately, it is a policy matter for government, but I can provide some additional contextual information. The bill includes the human rights principle that people with a disability have the same rights as any other members of society and to be empowered to exercise these rights. Anyone making a decision under the act has to consider that human rights principle when making those decisions. In terms of rights, that is an existing right that would be generally captured under the requirement to consider the same human rights as others. The Senior Practitioner will also need to comply with Queensland's Human Rights Act, which includes that right as well. While the bill does not necessarily call out that right, there are other protections in place.

CHAIR: The bill makes some consequential amendments to the Public Guardian Act and creates a new function for the Public Guardian. Would you be able to elaborate for the committee on the Public Guardian's newly created function?

Ms Tubolec: The Public Guardian has a unique role under the bill. As you mentioned, it amends section 13 of the Public Guardian Act to expand its functions in relation to 'relevant children' as they are defined under the Public Guardian Act—typically children in the child protection system. That means that, in relation to this particular reformed authorisation framework, the Public Guardian will have an involvement in the lives of children who are subject to the child protection system and who are subjected to restrictive practices through their child advocacy function and their community visitor (child) function. They will be able to monitor any concerns that the child may have in relation to the proposed use or ongoing use of restrictive practices. If through those services that the Public Guardian provides it becomes concerned with the use, it can seek an external review of that decision through the Senior Practitioner. The provision to amend section 13 of the Public Guardian Act really just supplements all of the other child functions that the Public Guardian already provides, and they will, through visible locations as defined under the Public Guardian Act, already be aware of restrictive practices that are proposed to be used. They will talk with the child. They will be able to observe if there are any issues. If the child wishes and raises it with the advocate then they can, on their behalf or on their own initiative, seek a review of that if there are concerns that it is being inappropriately used.

Mr BERKMAN: Interim behaviour support plans have lesser requirements to obtain. Does this lead to any risk that it might lead to misuse of restrictive practices?

Ms Rowe: No. The purpose of interim behaviour support planning is to get the kind of planning in place early and at the earliest opportunity and leading into more comprehensive behaviour support planning. It is a different process because of the need to start planning as soon as possible. Do you want to add anything, Amber? You are the behaviour support expert.

Ms Manwaring: As we have mentioned, the NDIS commission does oversight the development of the behaviour support plans, so both the interim and the comprehensive behaviour support plans. The intention of having an interim support plan, as Liz said, is to allow planning to be in place and consideration of that authorisation for the shorter term until a more comprehensive plan is done. The Senior Practitioner will use the same criteria for determining an authorisation, so it does not create any difference in consideration for the Senior Practitioner when it is used to support an application. The Senior Practitioner has the ability, under the bill, to ask further questions and get further advice if the Senior Practitioner is not satisfied that the application, which includes the interim behaviour support plan, has the information required to support an authorisation decision.

Ms Rowe: I have some additional information that I can provide. I cannot remember who asked about the implementation costs. I took that question on notice but I can provide some more information now. If that does not satisfy the member, we can take it further on notice; is that all right?

CHAIR: By all means, if you would like to clarify that now.

Ms Rowe: A question was asked about a more detailed breakdown around the funding that was provided. The $12.4 million is for the department to meet the increased demand of the current system. That will be going to the existing team that does this function in Queensland. The $20.1 million for implementation costs for the new framework includes $6.714 million over three years for an implementation team to manage the transition to the reformed framework and up to $2.5 million over four years for ICT hardware and management costs. Is that enough detail?

Dr ROBINSON: I do not want to hold up the committee, but if there is more detail and it is simple, can you give us whatever you have or otherwise take the rest on notice—whatever you have?

CHAIR: You can still take it on notice.

Ms Rowe: Yes.

CHAIR: That is fine. With that, I thank you for your evidence. That concludes this briefing. Thank you to everyone who has participated today. I thank our Hansard reporters. A transcript of the proceedings will be available on the committee's webpage in due course. Two questions were taken on notice: the one that was just raised with regard to funding the Senior Practitioner compliance team and the second from me on information about standards for market-based providers. Those responses are required by Tuesday, 16 July 2024 so that we can include them in our deliberations. I declare this public briefing closed.

The committee adjourned at 11.47 am.