



# ***HEALTH AND COMMUNITY SERVICES COMMITTEE***

**Members present:**

Mr TJ Ruthenberg MP (Chair)  
Dr AR Douglas MP (via teleconference)  
Mr JM Krause MP (via teleconference)  
Mr DE Shuttleworth MP

**Staff present:**

Ms S Cawcutt (Research Director)  
Ms L Archinal (Principal Research Officer)

## **PUBLIC BRIEFING—DISABILITY SERVICES (RESTRICTIVE PRACTICES) AND OTHER LEGISLATION AMENDMENT BILL 2013**

### **TRANSCRIPT OF PROCEEDINGS**

**THURSDAY, 5 DECEMBER 2013**

**Brisbane**

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Committee met at 2.02 pm

**KIDD, Mr Jason, Director, Disability Strategic Policy, Disability Services, Department of Communities, Child Safety and Disability Services**

**McNEILL, Ms Bronwen, Manager, Legal Policy, Disability Strategic Policy, Disability Services, Department of Communities, Child Safety and Disability Services**

**O'CONNOR, Ms Clare, Executive Director, Disability Services, Department of Communities, Child Safety and Disability Services**

**ROBERTSON, Ms Leanne, Director, Strategic Policy, Department of Justice and Attorney-General**

**NANKERVIS, Professor Karen, Executive Director, Centre of Excellence for Behaviour Support, The University of Queensland**

**CHAIR:** We have a quorum, so I declare open the Health and Community Services Committee's public briefing on the Disability Services (Restrictive Practices) and Other Legislation Amendment Bill. Our purpose today is to hear from officials from the Department of Communities, Child Safety and Disability Services and the Department of Justice and Attorney-General. My name is Trevor Ruthenberg. I am the member for Kallangur and chair of the committee. With me today is Mr Dale Shuttleworth MP, the member for Ferny Grove; and on the phone we have Dr Alex Douglas MP, the member for Gaven and Mr Jon Krause MP, the member for Beaudesert. We hope to have joining us the deputy chair, Mrs Jo-Ann Miller, the member for Bundamba. We have apologies today from Mrs Ros Bates MP and Mr John Hathaway MP.

I welcome our officials from the Department of Communities, Child Safety and Disability Services: Ms Clare O'Connor, Executive Director, Disability Services; Mr Jason Kidd, Director, Disability Services; Ms Bronwen McNeill, Manager, Legal Policy; Professor Karen Nankervis, Executive Director, Centre of Excellence for Behaviour Support, University of Queensland; and Ms Leanne Robertson, Director, Strategic Policy, Department of Justice and Attorney-General. Welcome. I remind those present that these proceedings are similar to parliament and are subject to the Legislative Assembly's standing rules and orders. Mobile phones should be turned off or switched to silent, please. Hansard is making a transcript of the proceedings. The committee intends to publish the transcript of today's proceedings unless there is good reason not to. Our proceedings today are also being broadcast live on the parliamentary website.

The Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2013 was referred to the committee on 20 November. The committee will hold a public hearing on 17 December and has invited written submissions on the bill by 9 January. We are required to report to the parliament on this bill by 3 February 2014. I invite Ms O'Connor to brief the committee about the bill.

**Ms O'Connor:** Thank you very much. Mr Chairman, to assist the committee this afternoon I wanted to cover a number of matters. First of all, I wanted to make a brief comment on the current regime and what is covered; talk about the legislative amendments, their purpose and benefits; the other initiatives that are being put in place to support the legislative amendments that are policy, education and communication initiatives; and also give the committee an insight into the process for this review, which may assist you to know who has been involved. In terms of expertise, Professor Nankervis is happy to answer any clinical questions you may have about the regime and Mr Kidd and Ms Robertson are happy to respond to legal policy questions on the legislation. I would point out at the outset, chair, that the context—

**Mr KRAUSE:** Chair, if it is at all possible for the speakers to utilise the telephone better, that would be great. I can hear the speaker, but only just.

**CHAIR:** Could you just pull that microphone closer to you, please, Ms O'Connor?

**Mr KRAUSE:** Thank you.

**Ms O'Connor:** Is that better?

**Dr DOUGLAS:** It is still very low. I agree with Jon.

**Ms O'Connor:** All right. I will try to project a little bit more. The context in which we are now working is changing. I think that is going to be very important for the committee's information. The National Disability Insurance Scheme will commence in Queensland in 2016 and be fully implemented by 2019. That will have a national restrictive practices framework and that is currently under development. So given that context the set of amendments we think are fairly modest. They have two main purposes. One is to make sure that we enhance the safeguards for clients while improving their quality of life and the other is to enable service providers to focus on clients and client services rather than on administration and red tape.

Just by way of background—I do not know how many people in the committee have been exposed to the regime before—back in 2006 the previous government became concerned about the type of practices that were being exercised in the sector and commissioned Judge Carter to do a review. He provided a report to the government and that report said that funded disability services were using restrictive practices too often and not expertly enough in relation to dealing with challenging behaviours of adults with intellectual and cognitive disability. Those kinds of challenging behaviours are behaviours that cause harm to themselves or to other people and can involve physical violence, for example.

Judge Carter's report also noted that the type of practices that were being exercised, in fact, could be unlawful if they were exercised outside a regulatory framework. So that is how we ended up with the two Acts—the Disability Services Act and the Guardianship and Administration Act having regulatory frameworks for restrictive practices. The restrictive practices that are covered under these pieces of legislation are containment, which prevents someone leaving a particular premises; seclusion, which confines an adult in a room; chemical restraint, which is medication; physical restraint; mechanical restraint, which could be using a device to restrict the movement of an adult or to prevent self-injury; and restricting access to objects. So that is the range of practices that are covered in both pieces of legislation.

The framework requires that a positive behaviour support approach is used. That approach is to reduce the restrictive practices over time and hopefully eliminate the need for their use. That approach means that someone will be assessed by a clinician who is appropriately qualified. There will be a plan developed about the use of the restrictive practices. There will be an approval given by a decision maker—the service providers are not the decision makers—and there will be regular review of those approvals. Those checks and balances exist for very good reason.

The other things that were put in place are practice support. We have the Centre of Excellence and that is a centre that Professor Nankervis heads and that has led research and development and training aimed at making sure that the sector is able to deliver these practices safely for our clients. We also have a Specialist Response Service, where we employ people to work with the service providers to prepare the plans and to make sure that the sector has that capacity to respond.

In terms of this review, the previous government did some work back in 2010 in response to service providers saying that the regime was too administratively burdensome. They held a number of consultations across the state. The current government had a look at that feedback and did not want to waste it but also released a discussion paper in July and August of this year. That discussion paper went out for a month and it went out very broadly. The people who you have written to as a committee are also the people who we provided the discussion paper to in order to comment.

At the same time we have had a working group made up of people from the disability sector, including the Public Advocate and the Adult Guardian. That working group came together throughout the year to consider the type of legislative amendments and the other policy and communication and education initiatives that would be required to improve this regime. We got about 38 submissions in response to the discussion paper. Essentially, the amendments that are proposed respond to the feedback that we got both from the discussion paper and from the working group. I could give you now the overview of the amendments. I have a little summary paper that might help the committee and I am happy to send it through to Sue electronically.

**CHAIR:** We just have to do a formal thing to allow you to table that. Dr Douglas, are you okay for Mrs O'Connor to table that document?

**Dr DOUGLAS:** Yes.

**CHAIR:** Jon, are you okay? Sorry, we are just going to stop until I can be sure that we have a quorum.

**Proceedings suspended from 2.13 pm to 2.17 pm**

**CHAIR:** We cannot contact Jon.

**Dr DOUGLAS:** Sorry, if I could help you I would.

**CHAIR:** We have sent a text and we have left voice messages. I do not know what is happening. Maybe there is—

**Dr DOUGLAS:** I had a lot of trouble. We got this this morning out the back of Nerang. Jon is on the other side of the mountain to me. If he is on Optus he could be having a lot of trouble.

**CHAIR:** Yes. The member for Beaudesert, we will keep trying to contact him. I am going to adjourn right now until we can get him back. We need him for a quorum. I apologise, I am not sure what is going on but we will just adjourn for five or so minutes and see if we can get him.

**Proceedings suspended from 2.18 pm to 2.25 pm**

**CHAIR:** We have a quorum again, so let me just start again. I now declare the hearing resumed and just reiterate that we have Dr Douglas and Mr Krause on the telephone while I and Dale Shuttleworth are here live, so we have a quorum. I am sorry; we still have to confirm that you can table the paper. Dr Douglas, are you okay for the paper to be tabled?

**Dr DOUGLAS:** Yes, I am happy with that.

**CHAIR:** Jon, just before you dropped out, Ms O'Connor wanted to table a paper. Are you okay for that to happen?

**Mr KRAUSE:** Of course.

**CHAIR:** Thank you. Dale is good and I am good, so we have general consensus. Please continue.

**Ms O'Connor:** Thank you, Chair, and I will work through the paper, and I do apologise; we did not realise people would be ringing in. In terms of the legislative amendment, if I can just underline the dual focus of improving protections and also enabling service providers to focus on clients rather than administration in that the legislative amendments are also supported by a suite of initiatives around education and policy reform as well to enhance practice. As we go through the legislative amendments, the first one is within the principles in part 10A emphasising the need for a positive behaviour support approach to support all adults with challenging behaviour, which we would view as being just good practice. In terms of making sure that service providers do not use restrictive practices as a form of punishment, that was raised at the working group and it is really about not withholding personal items, for example, to encourage good behaviour, and we made that very clear in the Bill. Providing for reporting on the use of restrictive practices by service providers, there was very strong support for introducing reporting during the review. At the moment we do some manual collection of data. However, I think that we could do a lot better, and reporting was one of the things envisaged originally but not implemented. So we are very keen to look at the Victorian reporting system, for example, where they do monitor the type of restrictive practices used and its frequency for each service provider.

Introducing a requirement for service providers to provide a statement to the adult and their families about the use of restrictive practices, the feedback from the review emphasised the need to involve families and the adult's network as early as possible and to empower them to exercise their rights and to make sure that they understand what the restrictive practice is and how it might be used and who would be making the decision and what avenues there are for complaint and review. In addition to that statement of course are those educative resources that we will make available and awareness training for professionals and family members. We also have a number of amendments to clarify the definitions of restrictive practices to make it very clear what is a restrictive practice and what is not, so simply guiding somebody to prevent them running into traffic makes good sense. People should not have to apply for an approval for that.

Reducing the prescriptive requirements in the positive behaviour support plans, there was a lot of feedback on this. At the moment plans can sometimes run to 100 pages and we had concerns expressed and we have concerns ourselves that those plans are not good, workable plans that a support worker can pick up and use easily. The Centre of Excellence has done a lot of work on a model plan and trying to reduce the requirements while meeting the decision-making requirements. Removing the requirement for a short-term approval to reduce that duplication and require the decision-makers to ensure that they have the correct information upfront so it is not a two-part

process. Making it easier for clients subject to the framework to transition to new service providers, at the working group it was identified that there is a block within the system. At the moment where somebody has a consent and then moves to a new service provider, it is difficult under the legislation—I think it is impossible—for them to immediately apply for a short-term approval, so we want to remove that block and make it easier for people to move and have the proper protections in place.

Clarifying the use of prescribed medication such as a sedative to facilitate a single instance of health care including dental treatment is not chemical restraint. The Adult Guardian provided us with that feedback and noted the current confusion, and we have included that amendment in the Guardianship and Administration Act. Providing time-limited immunity from civil or criminal liability where a service provider has sought a short-term approval or consent to the Adult Guardian and the approval or consent has not been decided before the existing approval or consent expires, that is subject to safeguards and we can talk in more detail about them if the committee is interested. The immunity of course will be time-limited and will be only where the use of restrictive practices is necessary to prevent harm and is the least restrictive way of keeping the adult and others safe, and there is a positive behaviour support plan in place.

We will be working with the office of the Adult Guardian to monitor the extent that the new immunity provisions are relied on. We also will be simplifying the legislation and using the new human services quality framework. Rather than insisting that people have a policy through the legislation, we will be checking there are policies in place on the ground through the human services quality framework and the third-party audits which are rigorous in nature and conducted on a regular basis, and stripping out some of that duplication. In stripping out the duplication, we have been very clear that we also preserve those requirements in division 6 to make sure that service providers have the skills, abilities and knowledge to practise appropriately. We also make sure that the time frame for review is clear within the legislation. That is probably the summary in relation to the legislation. As I said, we have a number of other initiatives such as guidelines, educative resources and training that are on offer as well. Chair, I might pause there. We are happy to take the committee's questions.

**CHAIR:** There is no-one else who would like to address the committee at this point?

**Ms O'Connor:** Karen, would you like to say anything?

**Prof. Nankervis:** The overall intent of the legislation being to reduce red tape but also increase the quality of supports for people with intellectual disability subject to restrictive practices is an important element of the changes to this Act from a clinical perspective. The plans that have been prepared for the clients under this regime have been of very poor value in terms of having a compliance focus and not having a best practice and positive behaviour supports focus. The good work that has been achieved sometimes has been despite the processes and the legislative requirements.

**CHAIR:** Thank you. Dr Douglas and Mr Krause, if you would like to say something can you just state your name and then I will come back to you so you can ask a question? Let me open up the questioning. We are looking at this now and, as you stated earlier, we also have the national framework coming. Can you take us through that in more detail so I can better understand where we are here versus waiting for that to come along?

**Ms O'Connor:** Yes, Chair. As I mentioned, the National Disability Insurance Scheme is on its way. The Queensland government signed the heads of agreement with the federal government in May 2013. That scheme will commence in the state in 2016 and be fully implemented by 2019. For us, we had to bear in mind that there is under development a national framework for restrictive practices. Professor Nankervis is contributing in terms of the research for that framework and we have had the opportunity to comment on drafts, but we have been expecting it this year. We have not got the final as yet.

This set of amendments, as I said at the beginning, is modest in nature, sensible and will improve practice, but we certainly did not want to have a major overhaul of our regime that would cost government and service providers money before we have a national framework which we will have to implement anyway. Our primary role is in looking to improve safeguards and to make sure that the service providers for the next few years can focus on clients rather than being tied up in administration red tape. Professor Nankervis's comments about the plan are relevant here. We have had a lot of feedback that the plans are difficult for people to use when providing care, that they are difficult for decision-makers to use and that they take a lot of time to work through. As I said, some of them run to 100 pages. The Centre of Excellence has done a lot of work with the

decision-makers and, in light of best practice, feel that they can reduce the plans to 20 workable pages or fewer and take into account a person's need and make it a sensible plan that a worker can pick up and use. That is one example of the kinds of amendments we are putting forward here that make good sense but do not take on the world at a point when the NDIS is on its way.

**CHAIR:** When would you expect the national framework might be available?

**Ms O'Connor:** We would be hoping to see a final version very soon, but that is really up to the National Disability Insurance Agency and the federal government. We have seen drafts of it, as I said, this year. Jason, do you have any better advice on how quickly we will see it?

**Mr Kidd:** The only thing I would add to that response, Clare, is that there is work on a draft national framework which provides high-level principles. We do not have a date but we have been involved in consultation on that and we are aware that the approach outlined there is consistent with our regime and the changes we are making, and probably just to distinguish that from any regulatory framework that might arise at a national level. We do not have detail on that at this stage.

**CHAIR:** Would you anticipate that would be a national framework that would be implemented in each state—in other words, you would have mirror regulation—or would you see that as federal regulation that would have precedent?

**Ms O'Connor:** I do not think we know at this stage.

**CHAIR:** So we are really some way away. What is being developed is a framework which is a high-level document.

**Ms O'Connor:** That is right.

**CHAIR:** There is some fairly significant detail in some of this. What I am hearing, though, is you do not anticipate there will be much redundancy, if at all, between the two given your current involvement in the development of that framework.

**Ms O'Connor:** We think that the principles are consistent. We are not in a position at the moment until we see the final to comment as to whether elements of our legislation may be deemed to be more redundant or more developed than other jurisdictions. We know that it varies across the country at the moment. How the national principles are put into play is yet to be determined.

**CHAIR:** I will just declare my hand. I think the recommendations for the bill seem to be fairly common sense in approach. When you first go to a home that is designed to enable restrictive practices, it can be quite confronting. I understand pretty well the implication of the long, drawn-out requirements and how long it may take sometimes to get to that point. There are some pretty big people out there who struggle to maintain control of their thought processes.

**Mr SHUTTLEWORTH:** I have a couple of questions and they may require very short answers, but I need some clarification. My reading of the bill was that this was targeted at adults only.

**Ms O'Connor:** It is.

**Mr SHUTTLEWORTH:** The chair's final statement is that there are some pretty big 15- to 17-year-old minors. How are they covered? What actions are in place currently for the protection of their carers or service providers? Is it the child commissioner who oversees that?

**Ms O'Connor:** Would Professor Nankervis be able to respond to that in terms of the services that we provide to children? Because we do not think this particular regime is suitable to apply to children and young people. Do you want to comment about Evolve, Karen?

**Prof. Nankervis:** The services that are primarily provided to children under Disability Services are mostly around consultation assessment for children who are engaging in challenging behaviours, so they are not providing a direct accommodation service or direct service delivery to the children. Children under these amendments are actually a very small proportion of service users. The only ones that would be receiving any sort of accommodation service would be in the respite area and, again, that is for very limited periods of time.

Where I think there is greater interest around what we are doing with children is through education, child safety and youth justice. That is where I think some of that consideration needs to be taken. Our concern that we have around the use of restrictive practices with children is that we know it is highly dangerous when you start using those sorts of practices that you are using with adults, as children are more vulnerable both physically and emotionally if we are engaging in those practices with children. So there are both of those elements as to why we have not been looking at this for children.

**Mr SHUTTLEWORTH:** I have a few questions.

**CHAIR:** Please go ahead.

**Mr SHUTTLEWORTH:** Under Your Life Your Choice, an adult can choose their service providers. I think you indicated, Ms O'Connor, that the transferring of these restrictive practices plans would stay with the person. So the plan is for the person regardless of who is providing the service; is that right?

**Ms O'Connor:** Yes. If you want me to comment about Your Life Your Choice and the increased consumer choice and control, yes, we are very committed to that and the government has made a number of legislative amendments to achieve that. But we are also very committed to the protections and safeguards for people who are at the complex end of the spectrum and may be subject to this regime. Where a person who has lower level needs might make a decision or their family might make that decision with them to self-direct or self-manage their funding, for a person who is subject to the restrictive practices regime we would say that their choices would be limited in certain ways. One of those ways is that we would expect they would purchase their services from a funded disability service provider who is subject to a number of requirements in relation to their abilities to deliver restrictive practices safely and they have the training and the capacity to do so and they are covered under this regime. It is not an open-ended set of choices for these clients for their protection and those safeguards to be in place.

**Mr SHUTTLEWORTH:** So the authority for restrictive practices is twofold? There is the plan for the individual but the provider also has to have met criteria?

**Ms O'Connor:** That is right.

**Mr SHUTTLEWORTH:** So there are kind of two audit processes?

**Ms O'Connor:** That is right.

**CHAIR:** Dr Douglas or Mr Krause, do either of you have a question?

**Dr DOUGLAS:** I have quite a few in my mind. I am trying to get a handle on the progression towards the national framework. I do not have the bill in front of me. I have in my own mind a broad overview of the national framework. My fear is that what I have heard is that we are exempting ourselves from some of the changes largely with children. What process is in play to review what we are going to do and if we have to link into a national scheme? If we are not part of the national scheme we lose some of the advantages of being part of it. I know that it takes years before this starts. Can I hear something about that?

**Ms O'Connor:** Chair, are you happy for me to respond?

**CHAIR:** Please.

**Ms O'Connor:** This regime in its current state does not apply to children.

**Dr DOUGLAS:** Yes, I heard that.

**Ms O'Connor:** We are waiting at the moment to see the national regime in full and in its final form. We are also wanting to examine very closely its scope and its application. In terms of whether it extends in any way to children, we are not sure at the moment and we will not be sure until we see it. Professor Nankervis has advised in relation to our current arrangements where we use a lot of therapy and clinical responses to children but we do not use restrictive practices. Basically we do not have the advice to give you in terms of the national framework and its definitive position and scope.

**Dr DOUGLAS:** Can I ask the obvious question then: how are you going to define children? Are you going to define them by age or are you going to define it by a certain point of development? I am a GP. We routinely see this problem. The difficulty is in the handover or the transition of children at certain ages. How are you going to define that? Is it going to be age?

**Prof. Nankervis:** In terms of under the Disability Services Act?

**Dr DOUGLAS:** Yes.

**Prof. Nankervis:** For eligibility for disability services in the accommodation services the person has to be an adult as well as fulfil the criteria of having a disability that causes significant impairments for the individual. Apart from the respite care, it is on the basis of age.

**Dr DOUGLAS:** Are you setting 16, 18 as the age?

**Prof. Nankervis:** No, 18 is the age and then we have the concurrent child protection legislation that deals with children under the age.

**Dr DOUGLAS:** I will let the others go on.

**CHAIR:** Mr Krause?

**Mr KRAUSE:** I am right, thank you, Chair.

**CHAIR:** Go ahead, Mr Shuttleworth.

**Mr SHUTTLEWORTH:** If an adult transitions, for whatever reason, from a service provider into a Queensland Health facility for a period of time, during that stay at the Queensland Health facility what legislation would cover the restrictive practices at that point? Will it still be this legislation or would it be different?

**Ms O'Connor:** Mr Shuttleworth, do you mean a mental health facility, for example, or do you mean a health facility? It would be covered by the Mental Health Act if they are in a mental health facility.

**Mr SHUTTLEWORTH:** Within that act is there similar guidelines around restrictive practices?

**Prof. Nankervis:** In mental health, yes, there are.

**CHAIR:** Ms McNeill, would you like to say something?

**Ms McNeill:** I was going to say similar to what Clare was saying: in mental health facilities things like seclusion and mechanical restraint are regulated. If they just went to a public hospital, restrictive practices are not regulated in that setting. It depends on the setting.

**CHAIR:** The positive behaviour support plans, in her explanatory speech the minister said that the amendments will reduce the prescriptive requirements for the positive behaviour support plans. Can you help us get a handle on what that really means? How many adults currently have a positive behaviour support plan? Are we talking thousands, hundreds or tens of people?

**Prof. Nankervis:** At the moment we have 594 people who are subject to restrictive practices so therefore have a positive behaviour support plan under that regime. Positive behaviour support plans are actually a plan that should be developed and provided for anybody who is engaging in difficult behaviours. It is best practice regardless of whether or not they are subject to any restrictive practices.

**CHAIR:** Can you give us some practical examples of the changes to positive behaviour support plans that will result from the amendments made by clause 13 of the bill?

**Prof. Nankervis:** As Ms O'Connor said before, some of those plans that we are looking at are 100 pages. I have seen some that are 150 pages. When this was put together I thought it was quite unusual to have such a prescriptive area within the legislation that said all of these elements must be in a positive behaviour support plan when in reality what we know from research best practice about what is a good positive behaviour support plan it was not necessarily all of those elements. What we ended up with were plans where every bit of the legislation had to be put in there, even though it might have been a very simple change in a person's life that could have made a huge difference to them. So what we have done is we have taken what we know is best practice, and research based best practice, in positive behaviour supports, and we have put that into a template or a model plan for the service providers to be developing, or the people who are doing the assessments to do the developing. That comes down to around 12 pages and that is a good, as I say, high-quality positive behaviour support plan. It has all the elements in it that we know are going to contribute to a better outcome for the person.

**CHAIR:** Something a person can digest.

**Prof. Nankervis:** Something a person can digest, and with a two-page summary that is going to be digestible for workers and family members and, wherever possible, the service user themselves. What we have also added onto it, depending on how the legislative amendments go currently, for the decision makers is a very clear piece of information that notates the plan of where it meets the decision making requirements under the legislation. So what it will also do is it should make the decision making a lot easier for those decision makers and move things along pretty quickly because instead of trying to trawl through 150 or 100 pages, they are going to see immediately where it is notated. Those notated areas do not stay with the plan, they go with the plan to the decision-makers. In the development of this plan we have consulted extensively with the Public Advocate, with the Office of the Adult Guardian, QCAT and service providers. We even ran focus groups with disability support workers to see whether or not they understood the plan now that it was written in this way. Certainly from my clinical professional background this is the plan I would have liked to have seen in place.

**CHAIR:** Thank you. I am going to finish off with another question. Are there any circumstances where a positive support behaviour plan would not be prepared for an adult who is subject to restrictive practices?



**Ms McNeill:** Yes, there are some circumstances. When someone first applies for a short-term approval there is no requirement for a positive behaviour support plan to be developed in that case for that period and that is to allow someone to undertake the assessments and develop the plan. So if a short-term approval is in place there will not be a plan in place where practices are used then. Also in respite and community access settings there is a different plan required. It is similar to a positive behaviour support plan but it is a bit more of a lighter touch plan because I guess in those settings the adults are not residing in those settings for as long a periods as they are in general accommodation support. So that is called a respite and community access plan. You can see in the legislation, I think that is 123ZP maybe, those requirements are listed out there. That would be the circumstances.

**CHAIR:** Thank you. Mr Shuttleworth?

**Mr SHUTTLEWORTH:** Is it possible that an adult could be under the guidance of these support plans and restrictive practices but not be provided for by you, so they could still be under the care of their own carer or a family member, or are they always inside a more controlled environment that the department is providing?

**Ms O'Connor:** This regime operates through funded service providers. So the care can be delivered in home settings and they can be group homes. For example, the accommodation and respite support service at the moment that is directly delivered by government currently has a number of people who live in group home settings where this regime is in place. Is that what you mean? It does not operate in the family home, if that is what you are asking.

**Mr SHUTTLEWORTH:** It is never going to occur where a carer or a family member is still providing ongoing care for these adults?

**Ms O'Connor:** This is about service providers.

**Ms McNeill:** It never authorises the use of restrictive practices by those family members or carers, but it does in the case of the use by funded disability support workers.

**CHAIR:** Dr Douglas?

**Dr DOUGLAS:** I understand what is transpiring. I have no further questions.

**CHAIR:** Mr Krause?

**Mr KRAUSE:** No questions, thank you.

**CHAIR:** I have one more. I want to go back to that second point. I am looking at the sheet you handed out under .2, facilitating greater focus on client service delivery. Two dot points up from the bottom, providing limited time immunity from civil and criminal liability in limited circumstances where there are delays in deciding an approval or consent, can you just go into that a little bit for me, please? What circumstances would that be under and why would that be needed?

**Ms O'Connor:** During the review several service providers raised concerns that there were delays in obtaining approvals and consents to use restrictive practices and that uncertainty that is created by those delays was placing them at risk of using the practices without immunity from civil and criminal liability. If they do not have a current approval to use it then they could be operating in an unlawful way. The delays can result for a number of reasons. The decision maker may need further information to be provided or seek further professional advice or request that it be obtained or there could be some operational delays due to fluctuating numbers of applications and that can occur, for example, in the Adult Guardian's office. There are two circumstances envisaged where a funded disability service provider may get time-limited immunity and one is where a service provider has sought a short-term approval for a new practice in relation to an adult who is already the subject of a positive behaviour support plan and the decision for the short-term approval has not been decided. The second circumstance is where the Adult Guardian is the guardian for a restrictive practice matter and the consent for the Adult Guardian to use a practice has expired before the Adult Guardian has decided whether a new consent can be made. So what we are saying is it is not in the interest of the service provider or the client to have a situation where there is no immunity for that service provider. We do envisage that it is time-limited and under very strict circumstances, so they still have to prove that it is beneficial to the client.

**CHAIR:** This would be a circumstance where approval had not been given yet but restrictive practices are required on a practical level to be implemented?

**Ms O'Connor:** It is where a short-term approval has been sought for someone who is already subject to a positive behaviour support plan and the decision for the short-term approval has not been decided or in the Adult Guardian's office where the consent to use a practice has

expired before the Adult Guardian has determined that they can provide the new consent. It does come though with some constraints: it is only for a certain period of time and it really requires them to still continue to demonstrate that the practice is the least restrictive way of ensuring the safety of the adult or others and that it is necessary to prevent the adult's behaviour causing harm.

**CHAIR:** So, in effect they could continue doing what they were doing until such time as approval came?

**Ms O'Connor:** Within a 30-day period, yes.

**CHAIR:** Right. I am sorry, Ms McNeill?

**Ms McNeill:** Yes, that is true. In the case of where the Adult Guardian has not decided to reconsent to an approval to a practice, in that case, yes, they could just keep doing what they are doing in accordance with the plan. The second case where we have provided a time limited immunity, though, is where the service provider sees that there is a reason to use a new practice. Perhaps a new behaviour has emerged. So in that case where there is a delay in deciding that approval we are providing some immunity, but in that case the adult is still being supported under a positive behaviour support plan.

**CHAIR:** But there are still checks and balances in place.

**Ms McNeill:** That is right and it needs to be least restrictive.

**CHAIR:** So could the 30 days be extended?

**Ms O'Connor:** No.

**Ms McNeill:** No.

**CHAIR:** Okay.

**Mr SHUTTLEWORTH:** How often would a restrictive practice decline in severity? How often would someone have a very restrictive practice placed upon them under these behavioural plans and then over a period of time improve to a point where that was now deemed to be excessive? How would that audit process be undertaken?

**Prof. Nankervis:** It varies, obviously, from individual to individual. If we look at people who have been subject to containment and seclusion, which is the highest regime of restrictive practice, we have had movement from around 2009 from 70-odd to 50-odd at the moment. So we have it, but it can be quite slow moving. The—

**Mr SHUTTLEWORTH:** Sorry, how is that audit undertaken? If it is a two-year approval, is that taken only every two years?

**Prof. Nankervis:** No, the service providers must be monitoring the efficacy of their plans constantly—so constant data collection—and that is where the Centre of Excellence provides support to the organisation. So what we do is we set up systems for them to be able to do that so that at all times they are able to monitor any of the changes. I think a two-year period for a review of an application for restrictive practices is reasonable given the slow nature of change. Sometimes people have been engaging in these behaviours for many, many years. But if there is a change, then that also would be triggering the opportunity to have a review of the circumstances of the restrictive practices at that time.

**Mr SHUTTLEWORTH:** So within a two-year period, if the condition improves to the point where they become less restrictive in their practice, but then there was a reversion to a point where they needed more, would they then have to reapply to escalate again?

**Prof. Nankervis:** If they have had a change in the approval, then they would have to go back and get a change to that approval. But if you look at the approvals that are provided by QCAT, for instance, they will say, 'This is the maximum period you can use this containment and seclusion.' So what the service provider is able to do is they are able to use less than that as often and, hopefully, as soon as possible, but if it escalates then they can move back up to what they currently have approval for.

**CHAIR:** Ms McNeill, do you have something to add?

**Ms McNeill:** I was just going to note that within the legislation there is a requirement for service providers to review the use of restrictive practices every 12 months. With the approval of containment and seclusion, that approval can last for only a maximum of 12 months and then it gets looked at again. So if behaviour has changed and less restrictive practices are required, that will be reflected in the next approval upon review.

**CHAIR:** So it does not get locked in for time in perpetuity.

**Ms McNeill:** Yes, that is right. There are review processes.

**CHAIR:** I have one more question. Again, I am staying in that area of making it easier for a restrictive practice client to move to a new service provider. How is the change allowing that or effecting that?

**Ms O'Connor:** Jason, did you want to comment?

**Mr Kidd:** Yes, when Clare referred to that change, what she was referring to is basically there could be some obstacles under the current legislation that prevent service providers obtaining short-term approvals when they start providing services to an adult who is already subject to restrictive practices. So where clients subject to restrictive practices change a service provider, they may not have the appropriate authorisations in place in advance to be able to prepare for the arrival of that client and make sure that they can use, say, an effective practice as soon as the client arrives. Where a client is receiving services from one service provider and that provider has the consent of a restrictive practice guardian to use a restrictive practice, currently a new service provider cannot get a short-term approval for the use of that same practice for the new service provider. Basically, this amendment addresses that.

The second scenario or obstacle relates to approvals from the Adult Guardian. Currently, under the Guardianship and Administration Act when there is an existing containment or seclusion order in place the new service provider also cannot apply for a short-term approval until the adult started getting a service provided by the new service. The amendment also addresses that.

The third scenario is in the respite or community access setting, where there is a respite guardian appointed for the adult and the client transfers. Currently, under the legislation a short-term approval could be sought. Again, this amendment addresses that blockage.

**CHAIR:** I appreciate that. Thank you. Dr Douglas, any further questions?

**Dr DOUGLAS:** No. Thank you for the briefing. It was very good.

**CHAIR:** Mr Krause?

**Mr KRAUSE:** I am okay, thank you.

**CHAIR:** Thank you. Mr Shuttleworth? I am just about to invite you to make a closing comment.

**Ms O'Connor:** Thank you. I just wanted to correct something for the record. I think I may have said before that the sedative for health care is under the GAA. It is under the DSA—the Disability Services Act.

**CHAIR:** All right. Would you like to make a closing comment? Is there anything that you think maybe we did not quite get or any other issues or concerns that you would like to bring to us?

**Ms O'Connor:** In terms of the legislative amendments, even though we are heading to the NDIS and the future is a little unknown, we think this set of amendments coupled with the policy and the education and the communication change and the good work that is being done by the Centre of Excellence will make a difference in the life of our clients and for the workers who deal with our clients on a daily basis. That is the intent of these amendments. It is a fairly modest set of amendments rather than an overhaul for all of those reasons.

**CHAIR:** Thank you. The time allocated for the public briefing, I think, we could pretty much say has expired, even though we had a short hiccup. Thank you all. Thank you for turning up. Thank you for your time. We appreciate you being here and spending time with us. We will provide you with a proof transcript of the briefing before publishing it on the committee's website. I declare the briefing closed.

**Committee adjourned at 3.07 pm**