

Reforming Queensland’s authorisation framework for the use of restrictive practices in NDIS and disability service settings

## Submission to

## Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships

### February 2022

# Table of Contents

[Summary 3](#_Toc94777896)

[Introduction 7](#_Toc94777897)

[Human rights in Queensland 7](#_Toc94777898)

[Restrictive practices and human rights 8](#_Toc94777899)

[Aboriginal people and Torres Strait Islander people 11](#_Toc94777900)

[Consultation 12](#_Toc94777901)

[Underlying principles and objects 13](#_Toc94777902)

[Scope of this Review 15](#_Toc94777903)

[Types of restrictive practices 17](#_Toc94777904)

[Containment 17](#_Toc94777905)

[Locking gates doors and windows 18](#_Toc94777906)

[Prohibited restrictive practices 18](#_Toc94777907)

[Authorisation and implementation 20](#_Toc94777908)

[Positive behaviour support plans 20](#_Toc94777909)

[Who should develop the PBSP? 21](#_Toc94777910)

[Consent-based model 22](#_Toc94777911)

[Who should authorise restrictive practices? 23](#_Toc94777912)

[Criteria for the authorisation and use of restrictive practices 25](#_Toc94777913)

[Authorisation of restrictive practices 25](#_Toc94777914)

[Implementation of restrictive practices 26](#_Toc94777915)

[Safeguards and oversight 28](#_Toc94777916)

[Review rights 28](#_Toc94777917)

[Reviewable decisions 28](#_Toc94777918)

[Meaningful rights of review 28](#_Toc94777919)

[Unauthorised use of restrictive practices 29](#_Toc94777920)

[Advocacy 30](#_Toc94777921)

[Personal information and privacy 32](#_Toc94777922)

[Transparency and data collection 32](#_Toc94777923)

[Evaluation 33](#_Toc94777924)

# Summary

1. Thank you for the opportunity to make submissions on options for reform to authorising restrictive practices in Queensland, including as outlined in the *Consultation Paper*,[[1]](#footnote-1) and in the *Independent Review* conducted by Griffith University.[[2]](#footnote-2)
2. Restrictive practices can have a significant, long term negative impact on a person’s human rights and humanity. While the Commission recognises that in a small number of cases these practices may be necessary to protect a person’s rights to life, safety and security as well as the rights of those around them, the goal of restrictive practices should be towards their elimination wherever possible, in favour of less restrictive options where these can be safely implemented. The Human Rights Act provides a useful framework for assessing where restrictive practices can be demonstrably justified and therefore assists with achieving this goal.
3. The following submission and recommendations focus on legislative and procedural reform for the authorisation of restrictive practices. However, it is clear that cultural change, training and education, and resourcing issues must be addressed if the overarching goal of eliminating restrictive practices is to be achieved. Some of these strategies are outlined in the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector.*

# Recommendations

1. The Commission makes the following recommendations in relation to the issues set out in the *Consultation Paper*:

[Restrictive practices and human rights](#_Toc95749981)

[**Recommendation 1:** A human rights compatible restrictive practices framework must acknowledge the human rights of all people, the limitation of those rights by restrictive practices, and that any limitation must be demonstrably justified.](#_Toc95749982)

[**Recommendation 2:** Special consideration, including further consultation, must be given to the rights and experience of Aboriginal people and Torres Strait Islander people subject to restrictive practices.](#_Toc95749983)

[**Recommendation 3:** The development of a restrictive practices authorisation framework must consider the views of people with lived experience and their supports, including people experiencing intersectionality, obtained through meaningful and targeted consultation.](#_Toc95749984)

[Underlying principles and objects](#_Toc95749985)

[**Recommendation 4**: The Commission recommends the inclusion of mandatory principles applicable to anyone when performing functions or exercising powers related to restrictive practices, which exceed the national principles and are consistent with human rights.](#_Toc95749986)

[Scope of this Review](#_Toc95749987)

[**Recommendation 5:** The Commission recommends that this review considers how reforms might extend to sectors other than NDIS plan recipients and people receiving department services, so that they may be adopted or extended for the protection of all people subject to the use of restrictive practices.](#_Toc95749988)

[Types of restrictive practices](#_Toc95749989)

[**Recommendation 6:** In relation to Queensland definitions of restrictive practices, the Commission recommends:](#_Toc95749990)

[(a) Adopting definitions of restrictive practice set out in the National Disability Insurance Scheme (Restrictive Practice and Behaviour Support) Rules 2018 (Cth) which will assist with national consistency, clarity, and data collection and evaluation.](#_Toc95749991)

[(b) Instead of distinguishing containment from environmental restraint, allow for less stringent authorisation requirements where the only restrictive practices sought is in relation to access to objects.](#_Toc95749992)

[(c) Expressly prohibit certain types of practices that are not to be used in any circumstances. This will include physical restraints that are known to carry an unacceptably high risk of injury or death, or practices which would amount to torture, cruel, inhuman or degrading treatment. Consideration should be given whether certain practices should be prohibited that would have a disproportionate impact on people with a particular attribute, for example children.](#_Toc95749993)

[Authorisation and implementation](#_Toc95749994)

[**Recommendation 7:** The Commission supports reform that will clarify and simplify restrictive practices authorisation processes, while still ensuring that there are adequate safeguards so that human rights limitations are demonstrably justified.](#_Toc95749995)

[**Recommendation 8**: The Commission considers that Positive Behaviour Support Plans for seclusion and containment do not need to be the sole responsibility of the chief executive of Disability Services, as is currently the case, although the chief executive, or other designated service provider, should be a Positive Behaviour Support Plan provider of last resort.](#_Toc95749996)

[**Recommendation 9:** The Commission supports a ‘senior practitioner’ authorisation model over a consent-based model of restrictive practices. Authorisation by a separate, independent expert provides a safeguard where restrictive practices have been ‘consented’ to. However, authorisation should not be given if a person objects to the use of restrictive practices and has the legal capacity to do so, unless there is reasonable justification, for example, where necessary to avoid imminent harm.](#_Toc95749997)

[**Recommendation 10:** The Commission recommends that entities with powers to authorise restrictive practices should be separate and independent from the service provider. If, as proposed in the Consultation Paper, an authorised program officer appointed by the service provider is given authority to authorise restrictive practices, there must be measures to ensure the independence and accountability of the authorised program officer.](#_Toc95749998)

[**Recommendation 11:** The functions of the senior practitioner should include authorisation, data collection, evaluation and monitoring, public awareness raising, education and advice, and research.](#_Toc95749999)

[**Recommendation 12:** Criteria for the authorisation of restrictive practices should reflect the proportionality considerations in section 13 of the Human Rights Act 2019 (Qld), and include evidence of efforts to reduce the use of restrictive practices.](#_Toc95750000)

[**Recommendation 13:** Criteria or conditions on the use of restrictive practices should reflect an assessment of whether their use is compatible with human rights and ensure they are applied in the least restrictive way.](#_Toc95750001)

[Safeguards and oversight](#_Toc95750002)

[**Recommendation 14:** The Commission recommends a framework that will comprehensively allow for the internal and external (QCAT) review of decisions to authorise restrictive practices.](#_Toc95750003)

[**Recommendation 15**: For review rights to be meaningful, service users need access to sufficient information, time and support to properly participate in the review.](#_Toc95750004)

[**Recommendation 16:** It is recommended that QCAT have a specialist list for restrictive practice reviews and/or have the support of assisting experts.](#_Toc95750005)

[**Recommendation 17:** Consideration must be given to whether current systems to identify and hold service providers accountable for unauthorised use of restrictive practices are sufficient.](#_Toc95750006)

[**Recommendation 18:** The Commission recommends embedding in legislation access to independent advocacy for people who are subject to restrictive practices, and mandatory representation for children.](#_Toc95750007)

[**Recommendation 19:** Any restrictive practices authorisation framework must take into account and adequately protect an individual’s right to information privacy and the right to seek and receive information under freedom of expression.](#_Toc95750008)

[**Recommendation 20:** The collection and publication of statistical and research data on the authorisation and use of restrictive practices must be mandated in legislation to allow for monitoring, evaluation and evidence-based reform.](#_Toc95750009)

[**Recommendation 21:** A commitment to evaluate against key objects, including the reduction and elimination of the use of restrictive practices, must be built into any reform, allowing sufficient time for changes to have effect and data to be collected.](#_Toc95750010)

# Introduction

1. The Commission is a statutory authority established under the Queensland *Anti-Discrimination Act 1991* (**AD Act**)*.*
2. The Commission has functions under the AD Act and the *Human Rights Act 2019* (**HR Act**)to promote an understanding and public discussion of human rights in Queensland, and to provide information and education about human rights.
3. The Commission also deals with complaints of discrimination, vilification and other objectionable conduct under the AD Act*,* reprisal under the *Public Interest Disclosure Act 2009*, and human rights complaints under the HR Act*.*

# Human rights in Queensland

1. The substantive provisions of the HR Act commenced on 1 January 2020. The HR Act establishes and consolidates statutory protections for human rights, primarily drawn from the United Nations *International Covenant on Civil and Political Rights*, and two rights from the *International Covenant on Economic, Social and Cultural Rights*.
2. The HR Act imposes obligations on:
	1. Parliament to consider human rights when making laws;
	2. Courts and tribunals to interpret laws compatibly with human rights, and to apply human rights in certain cases; and
	3. Public entities to act and make decisions compatibly with human rights, and give proper consideration to human rights when making decisions.
3. Statutory provisions of Queensland legislation must be interpreted in a way that is compatible with human rights (to the extent possible that is consistent with their purpose). International law and judgments of domestic, foreign, and international courts and tribunals may be considered in interpreting statutory provisions.[[3]](#footnote-3) This includes the *Convention on the Rights of Persons with Disabilities* (**CRPD**), a thematic human rights convention that interprets, extends, and transforms existing human rights as they apply to people with disability.[[4]](#footnote-4) Under the *National Disability Insurance Scheme Act 2013* (Cth) (**NDIS Act**), state and territory frameworks are expected to be consistent with the CRPD, as well as in line with the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Sector*.[[5]](#footnote-5)
4. Human rights protections are not absolute and may be subject under law only to reasonable limits that can be demonstrably justified. This is known as being ‘compatible with human rights’. Section 13(2) of the HR Act provides the following non-exhaustive list of factors when assessing compatibility:
	1. the nature of the human right;
	2. the nature of the purpose of the limitation, including whether it is consistent with a free and democratic society based on human dignity, equality and freedom;
	3. the relationship between the limitation and its purpose, including whether the limitation helps to achieve the purpose;
	4. whether there are any less restrictive and reasonably available ways to achieve the purpose;
	5. the importance of the purpose of the limitation;
	6. the importance of preserving the human right, taking into account the nature and extent of the limitation on the human right;
	7. the balance between the matters mentioned in paragraphs (e) and (f).
5. Once it has been established that a right has been limited by a public entity, the onus is on the public entity to justify the limitation. The standard of proof is high, requiring ‘cogent and persuasive’ evidence. The burden on public entities to justify limitations must be strictly imposed where the individual concerned is particularly vulnerable. [[6]](#footnote-6)

# Restrictive practices and human rights

1. Under section 9 of the NDIS Act, a restrictive practice is defined as ‘any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability’. The use of restrictive practices, by definition, limit human rights that are protected under the HR Act.
2. For people subject to restrictive practices, this can include significant limitations to:
* recognition and equality before the law (s 15);
* protection from torture and cruel, inhuman or degrading treatment (s 17);
* freedom of movement (s 19);
* freedom of expression (s 21);
* protection from unlawful or arbitrary interference with privacy, family, or home (s 25);
* protection of families and children (s 26);
* cultural rights, including of Aboriginal peoples and Torres Strait Islander peoples (ss 27 and 28);
* right to liberty and security of person (s 29);
* humane treatment when deprived of liberty (s 30);
* right to health services (s 37).
1. The person’s network of family, friends, and carers, might also be affected, including their rights to privacy, family and home (s 25), and the protection of families and children (s 26).
2. On the other hand, failure to impose restrictive practices may limit a person’s ability to pursue their personal goals and private life (s 25), and can be detrimental to the right to life (s16), security (s 29), and protection from cruel, inhuman or degrading treatment (s 17) for both the person and the people around them.
3. A Queensland framework for the authorisation of restrictive practices must start from a position that people subjected to restrictive practices have human rights, and that any limitation of those rights needs to be balanced and justified. Case study 1 shows how restrictive practices may be justified. Putting the person’s rights first helps guard against any ‘normalisation’ of restrictive practices, which contributes to ‘the dehumanisation of people with disability’.[[7]](#footnote-7)

Case study 1 - *Re Beth* [2013] VSC 189

In this case, the Supreme Court of Victoria considered an application in its *parens patriae* jurisdiction for orders to place 16-year-old Beth in a residential facility and to use restrictive interventions, including lock-up facilities and reasonable force.

Beth had been under the guardianship of the applicant, the Secretary of the Department of Human Services, since she was 4 years old. She had an intellectual disability, been subject to significant sexual abuse and violence, and multiple unstable placements. There were multiple incident reports of absconding, violence towards staff, property damage, and increasingly concerning sexualised behaviours.

Before making a decision, the court received significant evidence on what Beth’s goals and needs were, and how they could be provided for. The judge visited the accommodation and met with Beth who expressed a strong desire to stay at her current home and with current staff.

The court found that the restrictions were necessary to provide continuity and stability for Beth, and that she had made significant progress under them. The court was satisfied that if the orders were not made, Beth would be deprived of stable care, and would probably suffer significant harm and hindrance to her personal development.

The court also had regard to the fact that care provided to Beth would be in accordance with structured programs and plans, and subject to ongoing supervision of the Department of Human Services (including the Senior Practitioner), as well as independent vetting by community visitors, the Commissioner for Children, and Young People, and the Public Advocate.

In making the order permitting lock-up facilities and other restrictive interventions, the court added further safeguards that required:

* restrictions to be imposed only as far as reasonably necessary, and staff were required to seek to use less restrictive means;
* a comprehensive report to be prepared after 6 months by the Senior Practitioner;
* the matter to be listed for review on fresh evidence in approximately 12 months, and with parties allowed to apply for a review at any time; and
* independent legal representation for Beth upon review of the current order on a ‘best interest’ basis.
1. A restrictive practices framework that is compatible with human rights will:
	1. clearly identify the legitimate purpose/s for the use of restrictive practices;
	2. only authorise a restrictive practice if there is a rational connection between its use and the achievement of its purpose;
	3. only impose restrictive practices as far and for as long as reasonably necessary, and only as a last resort after investigation of less restrictive options;
	4. at every opportunity, work towards reducing and ultimately eliminating restrictive practices;
	5. apply without unlawful discrimination, and take into account other relevant attributes such as age, gender, or cultural and linguistic diversity;
	6. consult with the person with disability and their support network, and ensure their participation in decisions made about them;
	7. be transparent, clear, and accessible, including providing reasons for restrictions;
	8. have sufficient safeguards, including regular independent reviews, oversight, and evaluation.

#### **Recommendation 1:** A human rights compatible restrictive practices framework must acknowledge the human rights of all people, the limitation of those rights by restrictive practices, and that any limitation must be demonstrably justified.

## Aboriginal people and Torres Strait Islander people

1. Evidence taken by the Disability Royal Commission suggests disproportionate numbers of First Nations people may be affected by restrictive practices.[[8]](#footnote-8) Aboriginal and Torres Strait Islander people experience disability at around twice the rate of non-Indigenous Australians. They may have difficulty accessing NDIS plans and services due to communication barriers, mistrust of government services, socioeconomic disadvantage, and rural and remote locations.[[9]](#footnote-9)
2. Particular issues faced by Aboriginal people and Torres Strait Islander people subject to restrictive practices, as well as people from culturally diverse backgrounds, include ‘limiting engagement in traditional ceremonies, disallowing specific foods of cultural significance, or limiting engagement with other members of a particular cultural identity or spiritual belief’.[[10]](#footnote-10)
3. A restrictive practices authorisation framework must give special consideration to the rights and experience of Aboriginal and Torres Strait Islander people. While this needs to be the subject of further consultation, this may include the recognition of specific cultural rights, requiring cultural input in the development of positive behaviour support plans, access to interpreter and cultural support for individuals, and where appropriate ensuring decision makers have Aboriginal and Torres Strait Islander representation or expert assistance.

#### **Recommendation 2:** Special consideration, including further consultation, must be given to the rights and experience of Aboriginal people and Torres Strait Islander people subject to restrictive practices.

## Consultation

1. Article 4(3) to the CRPD obliges States to consult and actively involve people with disabilities through their representative organisations in the development and implementation of measures to give effect to the CRPD and in other decisions relating to persons with disabilities. The meaningful participation of people with disability in policies made about them promotes dignity and respect, fosters the development of person-centred, genuine solutions, is an opportunity for education and cultural change, and supports the exercise of choice and control.
2. While this obligation to consult is not expressly protected under the HR Act, it will be relevant in an assessment of whether a decision or statutory provision is compatible with human rights.
3. The *Consultation Paper* states the Queensland Government’s commitment to ‘working through what the national principles could mean for Queensland in close consultation with affected persons, their families and providers.’[[11]](#footnote-11) The Commission recommends this commitment extend to the development of any proposed framework and be supported by a strategy that allows for a proper and effective response on any proposals from the target group.
4. Consultation further needs to consider issues of intersectionality, targeting people with disability or lived experience who are also Aboriginal and Torres Strait Islander, younger people, older people, and people from linguistic and cultural diverse backgrounds, and how the use and implementation of restrictive practices can differently impact them.

#### **Recommendation 3:** The development of a restrictive practices authorisation framework must consider the views of people with lived experience and their supports, including people experiencing intersectionality, obtained through meaningful and targeted consultation.

# Underlying principles and objects

1. A human rights-compatible framework for restrictive practices should have objects and principles that are consistent with human rights, with which any person performing a function or exercising a power must comply.
2. Principles already exist for the authorisation of restrictive practices under the General Principles in section 11B of the *Guardianship and Administration Act 2000* (Qld) (**GA Act**), and in their use by service providers under sections 18, 141, and 142 of the *Disability Services Act 2006* (Qld) (**DS Act**).
3. As already outlined, the HR Act imposes obligations on public entities to act and make decisions compatibly with human rights and give proper consideration to human rights when making decisions.[[12]](#footnote-12) This applies to entities currently able to approve restrictive practices (that is, the Public Guardian, the chief executive of Disability Services, and the Queensland Civil and Administrative Tribunal) and to service providers who meet the definition of ‘public entity’,[[13]](#footnote-13) including registered NDIS providers when performing functions of a public nature. The HR Act does not apply to private guardians who have been appointed for restrictive practices, such as a family member or friend.
4. The Commission supports the inclusion of mandatory principles that are:
5. articulated specifically for the issues raised by restrictive practices;
6. apply universally to all persons involved (whether or not they are a public entity); and
7. reinforce for public entities the requirement to apply human rights

when performing functions or exercising powers related to restrictive practices.

1. The draft national principles[[14]](#footnote-14) agreed to by the then Disability Reform Council (now the Disability Reform Ministers Meeting) have been developed to guide the development of nationally consistent restrictive practices authorisation arrangements. The national principles do not reiterate the following requirements of section 21 of the *National Disability Insurance Scheme (Restrictive Practice and Behaviour Support) Rules 2018* (Cth) (**NDIS Rules**)that restrictive practices must:
* be used only as a last resort in response to risk of harm to the person with disability or others, and after the provider has explored and applied evidence-based, person-centred and proactive strategies;
* be the least restrictive response possible in the circumstances to ensure the safety of the person or others and reduce the risk of harm to the person with disability or others;
* be in proportion to the potential negative consequence or risk of harm; and
* be used for the shortest possible time to ensure the safety of the person with disability or others.[[15]](#footnote-15)
1. General principles underpinning a Queensland restrictive practices framework should also exceed the national principles, given the national principles:
	1. Do not recognise that people with disability have the same human rights, inherent dignity and worth, as all other people. Principle 3 only refers to the right of a person with disability to be free from abuse, neglect and exploitation.
	2. In Principle 3, only recognise the right to be free from abuse, neglect and exploitation ‘regardless of disability, age and where they live’. The principle of equality and non-discrimination is broader than these three attributes, and includes gender, sexuality, race and culture, and Aboriginal and Torres Strait Islander culture and identity.
	3. In Principle 4, refer to people and their support networks being ‘actively supported in the decision-making process’, which may not be the same as ensuring as far as possible their active contribution to and participation in that process.
	4. Do not refer to rights to privacy and confidentiality, and the right of a person to receive information about themself, although it may be implied by Principle 4.
	5. Do not include principles that promote the need for cultural change, training and education, adequate resourcing, data collection and evaluation if reduction and elimination of restrictive practices is to be achieved.

#### **Recommendation 4**: The Commission recommends the inclusion of mandatory principles applicable to anyone when performing functions or exercising powers related to restrictive practices, which exceed the national principles and are consistent with human rights.

# Scope of this Review

1. The current restrictive practices framework provided for under the DS Act andGA Actonly applies to adults with intellectual or cognitive disability who receive disability services from a relevant service provider. This includes NDIS service providers, the department, and department-funded service providers.
2. The Commission supports the proposal to extend the framework to any person receiving services funded by the NDIS, including children and people with disability other than intellectual or cognitive disability. It makes sense and is more equitable for everyone to benefit from the protections offered by the Queensland authorisation regime, rather than be distinguished because of age or type of disability. It would also increase clarity and provide consistency for NDIS service providers, who already have to comply with the requirements of the NDIS Rulesfor all clients.
3. The Commission understands that the scope of the *Consultation Paper* is limited to restrictive practices in disability service settings and for people receiving NDIS funding. However, restrictive practices occur in many other settings, such as hospitals, residential aged care, schools, at home, and at work.[[16]](#footnote-16) Some of these settings have authorisation frameworks, some are public entities with responsibilities under the HR Act, and some are largely unregulated.
4. People with disability regularly move between these settings, or receive services from multiple providers subject to different regulations.[[17]](#footnote-17) The many different approaches to restrictive practices has resulted in inconsistency, gaps, and confusion. Case study 2 is a recent Victorian example of this and the Commission understands similar issues are currently being considered by QCAT. The Commission recommends that this review considers how reforms might extend to other sectors, so that they may be adopted or extended for the protection of all people subject to the use of restrictive practices.

Case study 2 – *HYY (Guardianship)* [2022] VCAT 97

HYY is a 73 year old woman who required daily anticoagulant medication to reduce serious risk of stroke or thrombosis. While in hospital, HYY refused anticoagulant medication. The hospital sought consent from the Public Advocate for the treatment and use of physical restraint. The hospital also made an application to VCAT for guardianship.

VCAT appointed the Public Advocate as HYY’s guardian for medical treatment decisions, and indicated that restraint decisions may be ‘ancillary’ to medical treatment decisions. A further order was made that allowed the guardian to consent to physical restraint as a last resort, if there was no less restrictive way of administering anticoagulant medication to HYY.

The Public Advocate sought advice from VCAT regarding the authority to consent to physical restraint. Notably, the restraint in question was in relation to treatment for an ongoing serious medical condition, but was not required as an immediate or emergency response.

VCAT found that an appointment of a guardian for ‘medical treatment’ did not empower the guardian to authorise physical restraint for that medical treatment. Further, guardianship legislation did not allow for the appointment of a guardian for physical restraint, as restraint was not a ‘personal matter’ and was not a ‘thing necessary to be done to give effect to the power of the guardian’. Persuasive to this conclusion was the obligation to interpret legislation compatibly with the Victorian *Charter of Human Rights and Responsibilities*, and the lack of safeguards in the guardianship framework for the use of restraint, unlike in mental health and disability legislation.

The use of restraint for the purpose of medical treatment could only be authorised by order of QCAT under a specific section of guardianship legislation to ensure compliance with a guardian’s decisions.

1. There are examples of broader restrictive practices regimes in other jurisdictions. The *Senior Practitioner Act 2018* (ACT) regulates the use of restrictive practices by service providers in many settings including schools. The Explanatory Statement to the Act suggests that the Bill’s broad scope was to ‘to capture all people who are vulnerable and potentially subject to restrictive practice, not just those with disability’. The premise was to ensure the protection of all members of the community who may otherwise be subject to abuse or harm.
2. To leave vulnerable members of the community without such protection in Queensland, based on their funding status, may represent an unreasonable limitation on several rights protected in the HR Act including equality (s 15), protection of children (s 26) and privacy (s 25).

#### **Recommendation 5:** The Commission recommends that this review considers how reforms might extend to sectors other than NDIS plan recipients and people receiving department services, so that they may be adopted or extended for the protection of all people subject to the use of restrictive practices.

# Types of restrictive practices

1. The *Consultation Paper* raises the following issues in relation to the adoption of the definitions of restrictive practice set out in the NDIS Rulesinto Queensland law.

## Containment

1. The NDIS definition of ‘environmental restraint’ includes both ‘containment’ and ‘restricted access’ (as they are known in Queensland).
2. ‘Containment’ under the DS Act means to physically prevent the free exit of an adult from premises where the adult is receiving disability services in response to the adult’s behaviour that causes harm to themself or others, other than by secluding the adult.[[18]](#footnote-18) Seclusion also prevents free exit, except that the person is confined alone in a room or area.[[19]](#footnote-19) Authorisation for containment is treated in the same way as seclusion: short-term approval can be given by the Public Guardian, and general approval may be given following a hearing at QCAT.
3. On the other hand, ‘restricted access’ to objects can be authorised by the chief executive of Disability Services in the short term, or otherwise by a restrictive practices guardian. This is the same authorisation required for chemical, mechanical, or physical restraint. However, if no guardian has been appointed, restricted access to objects can be authorised by an informal decision-maker for the adult.
4. The *Consultation Paper* expresses concern that alignment with the NDIS Rules definitions of restrictive practices will result in containment being treated in the same way as restricted access to objects, which are ‘very different types of restrictive practices with very different potential impacts on people’s rights’.[[20]](#footnote-20) Notably, the Commonwealth definition of ‘environmental restraint’ goes beyond Queensland definitions of containment and restriction of access to objects, and includes practices that restrict access to the community or access to particular activities.[[21]](#footnote-21) A goal of the reforms should be adoption of simple definitions and authorisation processes that are easily understood and applied.
5. Should containment have greater authorisation requirements and safeguards than other forms of ‘environmental restraint’?
6. Arguably, containment does not need to have the same level of regulation and oversight as seclusion. In the prison context, Queensland courts have accepted that the adverse health effects of solitary confinement have been ‘well established’ in research and literature.[[22]](#footnote-22) Prolonged solitary confinement may amount to torture or cruel, inhuman or degrading treatment or punishment[[23]](#footnote-23) and its use, other than in cases of ‘urgent need’ and in ‘exceptional circumstances and for limited periods’, may be in breach of the right to humane treatment when deprived of liberty.[[24]](#footnote-24) Containment may also limit these rights, but arguably no more so than mechanical, chemical and other forms of restraint.
7. Perhaps a better approach is not to recognise containment as a subcategory of environmental restraint, but rather to allow for less stringent authorisation requirements where the only restrictive practices sought is in relation to access to objects.

## Locking gates, doors and windows

1. Consistent with the findings of the Ministerial review[[25]](#footnote-25) and with the definitions in the NDIS Rules, the Commission agrees that the practice of locking gates, doors, and windows should be regarded as containment or an environmental restraint requiring authorisation and oversight.

## Prohibited restrictive practices

1. The authorisation of restrictive practices and their implementation will likely be the decisions and actions of public entities bound by the HR Act. This submission has also recommended that there be principles underpinning restrictive practices legislation that will have a similar effect.
2. The list of prohibited practices in other jurisdictions provided in the *Consultation Paper*[[26]](#footnote-26) are likely to be in breach of Queensland’s HR Act. For example, it would be an unjustified limitation on human rights to use practices that:
	1. are for purposes other than the legitimate purpose – for example, where a restrictive practices is used as punishment, harassment, victimisation etc;
	2. are disproportionate to the purpose to be achieved;
	3. would put someone’s life at unreasonable risk;
	4. would amount to torture and cruel, inhuman or degrading treatment – that is, practices which intentionally or unintentionally inflict severe physical or mental pain or suffering, or result in the person’s humiliation.
3. For clarity, it would be desirable to expressly prohibit certain practices that should not be used in any circumstance. This would include certain physical restraints that are known to carry an unacceptably high risk of injury or death, or practices which would amount to torture, cruel, inhuman or degrading treatment. Given the evidence of significant harm as a result of prolonged seclusion briefly outlined in paragraph 44, there should be maximum timeframes and minimum conditions on the amount of seclusion that can be authorised.
4. Prohibited practices for children may differ from adults, due to a child’s physical, mental and emotional development. Similarly, other practices may need to be prohibited because they would disproportionately impact a person with a particular attribute.

#### **Recommendation 6:** In relation to Queensland definitions of restrictive practices, the Commission recommends:

#### Adopting definitions of restrictive practice set out in the National Disability Insurance Scheme (Restrictive Practice and Behaviour Support) Rules 2018 (Cth) which will assist with national consistency, clarity, and data collection and evaluation.

#### Instead of distinguishing containment from environmental restraint, allow for less stringent authorisation requirements where the only restrictive practices sought is in relation to access to objects.

####  Expressly prohibit certain types of practices that are not to be used in any circumstances. This will include physical restraints that are known to carry an unacceptably high risk of injury or death, or practices which would amount to torture, cruel, inhuman or degrading treatment. Consideration should be given whether certain practices should be prohibited that would have a disproportionate impact on people with a particular attribute, for example children.

# Authorisation and implementation

1. The Commission supports reform that will clarify and simplify restrictive practices authorisation processes and result in efficiency gains for service providers, which in turn will discourage the use of unauthorised practices.[[27]](#footnote-27) Equally, an accessible, timely, and more transparent framework for restrictive practices should translate into improved pathways for service users to challenge or seek amendment to restrictive practices.
2. Authorisation however must still fulfil its primary function of only permitting restrictive practices where strict criteria have been met, and always with a view towards reducing and ultimately eliminating their use.

## Positive behaviour support plans

1. A positive behaviour support plan (**PBSP**) provides a plan for the use of restrictive practices on a person. In Queensland, a PBSP must include:
	1. details of the restrictive practices proposed to be used;
	2. the circumstances and conditions under which restrictive practices can be used;
	3. justification for the use of restrictive practices, such as identifying the behaviour they are intended to address, consideration of less restrictive alternatives, and the positive and negative effects the practice will have on the person;
	4. measures in place to ensure that the person with disability is safe and has access to proper care and treatment;
	5. individualised positive strategies to reduce the intensity, frequency, and duration of the person’s identified behaviours so that use of restrictive practices can be reduced, and ultimately eliminated.[[28]](#footnote-28)
2. Under the GA Act, PBSPs are necessary for the authorisation of a restrictive practice, except for short-term approvals and practices used in respite or community access services[[29]](#footnote-29).
3. PBSPs are central to ensuring proper consideration of the person’s human rights and justifying their limitation, and to meaningfully work towards the reduction and elimination of restrictive practices. PBSPs must be developed by the right people, be available and communicated to the person with disability and their supports in a way they can understand, be regularly reviewed, and subject to external oversight.

### Who should develop the PBSP?

1. At present in Queensland, the development of PBSPs involving seclusion and containment are the responsibility of the chief executive of Disability Services, while other PBSPs are the responsibility of the service provider. PBSPs must be informed by expert functional behaviour assessments of the person and have input from: the person the subject of the restrictive practice; formal or informal decision-makers for the adult; service provider/s using the restrictive practices; any health or service providers whose views would be relevant; and the person’s family and other support networks.[[30]](#footnote-30)
2. It appears appropriate to align with NDIS Rules and shift both development and assessment functions of PBSPs to an NDIS behaviour support practitioner who has been assessed and deemed suitable for the role by the NDIS Commissioner. However, the PBSPs should still be subject to appropriate expert and independent scrutiny through the authorisation process. See section entitled ‘Who should authorise restrictive practices?’ below.
3. In order to address thin markets and any potential conflicts of interest, the chief executive of Disability Services, or another designated provider, should be a PBSP provider of last resort.

## Consent-based model

1. Under the GA Act, a restrictive practice can only be approved, or a guardian for restrictive practices appointed, if QCAT is satisfied that the person has impaired capacity for the matter.[[31]](#footnote-31) This means that if a person has legal capacity to consent to restrictive practices, then restrictive practices cannot be authorised.
2. The concept of consent to a restrictive practice is problematic. Can consent be ‘full, free and informed’ if the person is at risk of losing their disability supports if they do not consent? What relevance is the person’s education and understanding of the world? What if they change their mind? The person’s views, wishes, and preferences must be taken into account when authorising and implementing restrictive practices. However, even where there is an alignment of those views, wishes, and preferences with the use of restrictive practices, authorisation by a separate, independent expert allows for the continued safeguarding of the person’s rights.
3. If consent of the individual to authorise restrictive practices is not appropriate, it follows that neither is consent by a substitute decision-maker. The Public Advocate has noted the problems with relying on substitute decision-maker consent to restrictive practices, including consideration of other people’s safety when their duty is to the person with disability, and their lack of expertise.[[32]](#footnote-32)
4. On the other hand, any decision to authorise or use restrictive practices in circumstances where the person objects to their use and has legal capacity is a significant limitation on rights to equality and privacy, and must be justified. For example, where the use of the restrictive practice is necessary to avoid imminent harm.

## Who should authorise restrictive practices?

1. The Commission agrees with recommendations of the Public Advocate, and preferred option 3 outlined in the Independent Review, that there be appointed a ‘Senior Practitioner’, a highly qualified and experienced clinician to independently approve PBSPs and authorise the use of restrictive practices.
2. The *Consultation Paper* proposes the creation of ‘Authorised Program Officers’, as found in Victoria, to approve some forms of restrictive practices . Authorised Program Officers would be appointed by the NDIS provider and approved by the Senior Practitioner. Under the current Queensland framework, no restrictive practice can be authorised by a person who has a connection to the service provider. In the Commission’s view, the continued separation of the authorising entity, and the service provider, is preferred. As identified by the *Consultation Paper*, there are also practical concerns regarding market readiness and capacity to perform this function.[[33]](#footnote-33) There will need to be careful consideration of the oversight functions and other safeguards in place to ensure the independence and accountability of the Authorised Program Officer if this model is to be adopted.
3. Centralising the authorisation of restrictive practices simplifies processes for service providers, increases consistency and expertise in restrictive practice decision-making, and allows for comprehensive data collection on the use of restrictive practices in Queensland. The Senior Practitioner could also have a role in providing expert feedback and guidance on the content of PBSPs, including alternative strategies to address behaviours other than through restrictive practices.
4. The Senior Practitioner would be well placed to also have functions to evaluate and monitor, raise public awareness, provide education and advice, and undertake research. Given that these functions would be Queensland-focused and performed at the discretion of the Senior Practitioner, it is unlikely that they would unnecessarily duplicate the work of the NDIS Commissioner.
5. This submission does not comment on what types of restrictive practices should be authorised by the Senior Practitioner and what types should be authorised by Authorised Program Officers. However, it is apparent that there would be three ‘levels’ of authorisation depending on the extent of the restriction proposed. They are:
	1. authorisation by the Senior Practitioner alone;
	2. approval of the PBSP by the Senior Practitioner and authorisation of the restrictive practice in accordance with the PBSP by the Authorised Program Officer;
	3. authorisation by the Authorised Program Officer alone.
6. In the Commission’s view, it is not necessary for QCAT to retain an authorisation function for containment and/or seclusion, but should still provide an external review mechanism, which is outlined below.

#### **Recommendation 7:** The Commission supports reform that will clarify and simplify restrictive practices authorisation processes, while still ensuring that there are adequate safeguards so that human rights limitations are demonstrably justified.

#### **Recommendation 8**: The Commission considers that Positive Behaviour Support Plans for seclusion and containment do not need to be the sole responsibility of the chief executive of Disability Services, as is currently the case, although the chief executive, or other designated service provider, should be a Positive Behaviour Support Plan provider of last resort.

#### **Recommendation 9:** The Commission supports a ‘senior practitioner’ authorisation model over a consent-based model of restrictive practices. Authorisation by a separate, independent expert provides a safeguard where restrictive practices have been ‘consented’ to. However, authorisation should not be given if a person objects to the use of restrictive practices and has the legal capacity to do so, unless there is reasonable justification, for example, where necessary to avoid imminent harm.

#### **Recommendation 10:** The Commission recommends that entities with powers to authorise restrictive practices should be separate and independent from the service provider. If, as proposed in the Consultation Paper, an authorised program officer appointed by the service provider is given authority to authorise restrictive practices, there must be measures to ensure the independence and accountability of the authorised program officer.

#### **Recommendation 11:** The functions of the senior practitioner should include authorisation, data collection, evaluation and monitoring, public awareness raising, education and advice, and research.

## Criteria for the authorisation and use of restrictive practices

1. As with the current framework, there will be criteria for the authorisation of restrictive practices, and then another set of criteria to be applied by service providers at every instance of their use. The HR Act would provide an additional layer of protection by requiring public entities, such as the Senior Practitioner, Authorised Program Officers, and NDIS service providers, to give proper consideration to and/or act compatibly with human rights protected under the HR Act.
2. The remainder of this section makes suggestions on what should be included in the criteria for the authorisation and use of restrictive practices, but is not intended to be an exhaustive list.

### Authorisation of restrictive practices

1. Authorisation criteria should reflect proportionality considerations under section 13 of the HR Act, as outlined in paragraph 11 of this submission. The PBSP itself should be assessed for human rights compatibility in relation to all human rights that might be limited by it.
2. There should be evidence of:
	1. the identified behaviour of the individual and its impacts that the restrictive practice is intended to address;
	2. the impact of the proposed restrictive practice on the individual, taking into account the individual’s circumstances such as age, cultural considerations, and history of trauma;
	3. efforts to explain the purpose and effect of the PBSP to the individual;
	4. the views, wishes and preferences of the individual (and if they refuse the restrictive practice, and have capacity to do so, then the restrictive practice should not be authorised – see paragraph 62 of this submission for further discussion);
	5. input from the person’s formal and informal support network and other providers who know the person best;
	6. less restrictive strategies that have been investigated, such as skills development or changes to built-environment, and why they have not been sufficient;
	7. whether the positive strategies in the PBSP can in fact be achieved within the current levels of NDIS funding, or the status of any NDIS plan review (in particular, this may impact on the length of time restrictive practices will be authorised);
	8. where relevant, efforts to implement positive strategies to address causes of behaviour, and whether this has reduced the use of restrictive practices. See for example case study 3.

Case study 3 – *Owen-D’Arcy v Chief Executive, Queensland Corrective Services* [2021] QSC 273

Mr Owen-D’Arcy was a prisoner who had been held in solitary confinement for more than 7 years. For a number of years, a psychologist had recommended the development of a long term strategy in relation to therapeutic treatment that would allow Mr Owen-D’Arcy to progress through the Maximum Secure Unit. These recommendations had not been followed.

Mr Owen-D’Arcy sought judicial review regarding Queensland Corrective Services’ most recent decision to place him on a Maximum Security Order for a further 6 months, and a no association order.

The court found that Mr Owen-D’Arcy’s right to humane treatment had been limited and that Queensland Corrective Services had not demonstrated that the limitation was justified.

Relevantly, Queensland Corrective Services did not provide evidence that there were no less restrictive alternatives available to manage the risk of violence to the general prison population. Further, in balancing the purpose of the limitation against rights, Queensland Corrective Services did not take into account the fact that even though the Maximum Security Order is only effective for 6 months, Mr Owen-D’Arcy had effectively been in solitary confinement for 7 years, and that the recommendations of the psychologist had had little prospect of implementation.

1. The appropriate period for the authorisation of a restrictive practice is likely to be fact-specific. Based on current timeframes under the GA Act, as well as under timeframes for review of involuntary orders by the Mental Health Review Tribunal under the *Mental Health Act 2016* (Qld), maximum timeframes for the authorisation of restrictive practices should not exceed 1 year, and possibly occur more frequently in their first year.

### Implementation of restrictive practices

1. Just because a restrictive practice has been authorised does not mean that they should be imposed. Before each use of restrictive practices, there should be an assessment of whether, in the particular circumstances, the use is compatible with human rights. In other words, authorisations set out a maximum level of restrictions permitted, but the goal should always be to use the least restrictive option possible.
2. A human rights assessment does not have to be a technical or laborious exercise. Key questions could include:
	1. Is the practice authorised?
	2. Is the practice in compliance with the PBSP?
	3. Is its purpose to prevent harm or some other purpose?
	4. Have less restrictive alternatives been considered?
	5. Will the individual be physically and mentally safe?
	6. Does the risk and extent of harm outweigh the adverse impacts on rights of the individual?
3. The weighing up of harm and rights needs to reflect national principle 7 that ‘authorisation arrangements promote independence and dignity of risk’. This was also illustrated in evidence to the Disability Royal Commission: ‘there is a tendency to approach risk with an all-or-none attitude focusing on preventing the worst possible outcome, no matter how small the possibility. The result of this is often a restrictive practice that is not proportional to the probability of the risk occurring’.[[34]](#footnote-34)
4. Taking into account the views, wishes and preferences of the individual should be built into considerations of whether there are less restrictive alternatives. Processes need to ensure the person is, as far as possible, informed of the practice to be used, the length of time it will be used, and the reasons for it.

#### **Recommendation 12:** Criteria for the authorisation of restrictive practices should reflect the proportionality considerations in section 13 of the Human Rights Act 2019 (Qld), and include evidence of efforts to reduce the use of restrictive practices.

#### **Recommendation 13:** Criteria or conditions on the use of restrictive practices should reflect an assessment of whether their use is compatible with human rights and ensure they are applied in the least restrictive way.

# Safeguards and oversight

## Review rights

### Reviewable decisions

1. A fundamental safeguard to the authorisation and use of restrictive practices are comprehensive, accessible and meaningful rights of review where rights have been limited.
2. As outlined in the *Consultation Paper*:
	1. QCAT authorisation of seclusion and containment is reviewable by QCAT on their own initiative, or upon application.
	2. The appointment of a restrictive practices guardian is reviewable by QCAT – again, either on QCAT’s own initiative or by application.
	3. The chief executive’s decision *not* to conduct a multidisciplinary assessment, or to *not* develop a PBSP for a person (which means that seclusion or containment for a person will not be authorised) may be subject to internal review upon application.[[35]](#footnote-35)
3. There are gaps in this framework, such as mechanisms to directly review decisions to authorise restrictive practices made by guardians.
4. The Commission recommends a framework that will comprehensively allow for the internal and external (QCAT) review of decisions to authorise restrictive practices. If the model proposed by the *Consultation Paper* is adopted, then the following decisions should be reviewable:
	1. Senior Practitioner decisions to authorise, or refuse to authorise, restrictive practices;
	2. Authorised Program Officer decisions to authorise, or refuse to authorise, restrictive practices;
	3. Senior Practitioner decisions to appoint, not appoint, or revoke the appointment of an Authorised Program Officer.

### Meaningful rights of review

1. For rights of review to be meaningful, they need to be communicated to the service user and their support network in a way they understand. The service user should have access to any information that will be considered in the review, or at least have the information explained to them with sufficient time to process and respond. They should have the opportunity and the support to participate in reviews, including any hearing. This may require help from an advocate, which is discussed in the next section of this submission.
2. Given the complex and specialist subject matter, it would be desirable for QCAT to have a specialist list for restrictive practice reviews and/or have the support of assisting experts. The *Child Protection Act 1999* (Qld) currently requires the tribunal to be constituted by at least one legally qualified member who has extensive professional subject matter knowledge.[[36]](#footnote-36)

#### **Recommendation 14:** The Commission recommends a framework that will comprehensively allow for the internal and external (QCAT) review of decisions to authorise restrictive practices.

#### **Recommendation 15**: For review rights to be meaningful, service users need access to sufficient information, time and support to properly participate in the review.

#### **Recommendation 16:** It is recommended that QCAT have a specialist list for restrictive practice reviews and/or have the support of assisting experts.

## Unauthorised use of restrictive practices

1. Further consideration should be given to whether reform is needed to identify and hold service providers accountable for unauthorised use of restrictive practices. Unauthorised use includes situations where there is no authorisation, where use exceeds authorisation, and where use is an unjustified limitation of human rights.
2. Existing frameworks include:
	1. criminal and civil law remedies;
	2. the NDIS Quality and Safeguards Commission;
	3. Community Visitors Program;
	4. Obligations to establish a National Preventative Mechanism under the United Nation Optional Protocol to the Convention against Torture;
	5. Complaints to the Commission under the AD Act or HR Act.
3. While the Commission can accept complaints against NDIS service providers for alleged breaches of human rights, it appears that few if any have been accepted since the HR Act commenced on 1 January 2020.[[37]](#footnote-37) Complaints under the HR Act are resolved through conciliation. The Commission has no powers to make or enforce findings, although it can publish reports in relation to unresolved complaints with recommendations on what action the respondent public entity should take to be compatible with human rights.[[38]](#footnote-38)
4. There are also difficulties in accountability mechanisms that are complaints driven. People with disability are often not in a position to challenge the people who have authority or power over them, and face multiple barriers in accessing legal processes.
5. Also relevant here is the issue of ‘thin markets’ for specialised positive behaviour support, particularly in rural and remote areas, as identified by the Queensland Productivity Commission.[[39]](#footnote-39) Lack of choice increases the power differential between service user and service provider, with service users less likely to make a complaint or change service providers, and service providers having less incentive to reform their practices. However, strategies to increase quality and quantity of services should not come at the expense of safeguards, as was suggested in the Ministerial review to retain the power under s 140(2) of the DS Act, which allows particular service providers to be excluded by regulation from the authorisation framework.[[40]](#footnote-40)

#### **Recommendation 17:** Consideration must be given to whether current systems to identify and hold service providers accountable for unauthorised use of restrictive practices are sufficient.

## Advocacy

1. In *Re Beth*, independent representation was identified as a significant safeguard ‘against the inappropriate exercise of the disproportionate power which the Secretary will hold in respect of Beth under the proposed order’.*[[41]](#footnote-41)* The judge considered a series of New South Wales Supreme Court decisions in which the court adopted the practice that children the subject of *parens patriae* proceedings be represented as they would in child protection proceedings before the Children’s Court.[[42]](#footnote-42)
2. The *Mental Health Act 2016* (Qld)guarantees legal representation for certain patients appearing before the Mental Health Review Tribunal, including children, hearings regarding electroconvulsive therapy, and in forensic order review hearings where the Attorney-General is represented at the hearing.[[43]](#footnote-43)
3. Many people with disability face barriers to accessing justice because of the lawyers’ duty to follow the client’s ‘competent instructions’[[44]](#footnote-44) and reluctance to take instructions from someone viewed as having questionable capacity. While the recent *Queensland Capacity Assessment Guidelines 2020*[[45]](#footnote-45) may go some way to dispel myths and increase legal literacy on this issue, law reform in relation to restrictive practices should consider how this issue may be addressed. In mental health legislation, the role of a patient representative is defined as:
	1. to the extent the person is able to express the person’s views, wishes and preferences – to represent the person’s views, wishes and preferences; and
	2. to the extent they are unable to express their views, wishes and preferences – to represent the person’s best interests.[[46]](#footnote-46)
4. To safeguard the rights of people with disability subject to restrictive practices, people should have access to independent advice and representation, support through the authorisation process, and advocacy outside formal review processes.
5. Independent advocacy must be adequately resourced, accessible to people living under restrictions, and provided by suitably qualified and trained people.

#### **Recommendation 18:** The Commission recommends embedding in legislation access to independent advocacy for people who are subject to restrictive practices, and mandatory representation for children.

## Personal information and privacy

1. The authorisation and implementation of restrictive practices will necessarily require the collection, use, and retention of sensitive and substantial personal information about an individual, which will be shared between many service providers and other entities over many years.
2. The goals of fully informed decision making, monitoring and evaluation, and administrative convenience, must be balanced against proper protections for an individual’s right to be protected from arbitrary or unlawful interference with their privacy protected by s 25 of the HR Act. Individuals also have the right to seek and receive information under the freedom of expression in s 21 of the HR Act.
3. Protection of these rights include, as far as possible, consent of the individual, the right to know what information is stored about them, who might access the information and what for, the right to receive the information, and adequate procedural safeguards against unauthorised access and disclosure.[[47]](#footnote-47)
4. Regulations regarding privacy must be accompanied by training and resources for service providers to understand their privacy obligations, and awareness raising for service users to understand their rights.

#### **Recommendation 19:** Any restrictive practices authorisation framework must take into account and adequately protect an individual’s right to information privacy and the right to seek and receive information under freedom of expression.

## Transparency and data collection

1. Article 31 of the CRPDrequires States to collect statistical and research data to assist them to formulate, implement, monitor, and evaluate policies and other measures that implement the CRPD. Collection must be mindful of the privacy rights held by individuals and have adequate safeguards. States are also obliged to disseminate the information to people with disability and ensure that the information is accessible.
2. Submissions to the Disability Royal Commission have noted:

… there is limited data available to accurately determine the use and prevalence of restrictive practices on people with disability. The absence of data is a barrier to the development of evidence-based policy, procedures and practices. It also prevents evaluation of the impact of restrictive practices.[[48]](#footnote-48)

1. The absence of data also makes it difficult to engage in debate, hold the government to account, identify trends or systemic issues, or to evaluate any progress towards achievement of the goal of reducing and ultimately eliminating the use of restrictive practices.
2. The collection and publication of data on the authorisation and use of restrictive practices should be mandated within Queensland legislation. This could be included in the requirements for the annual report of the Senior Practitioner.

#### **Recommendation 20:** The collection and publication of statistical and research data on the authorisation and use of restrictive practices must be mandated in legislation to allow for monitoring, evaluation and evidence-based reform.

## Evaluation

1. The Commission notes from the Independent Review that ‘Various regulatory frameworks in Australia have not been evaluated to determine whether and how the authorisation processes and accompanying policy frameworks induce changed practices to facilitate eliminating the use of restrictive practices’[[49]](#footnote-49).
2. Evaluation is necessary to assess the achievement of goals and supports continuous improvement. There must be a commitment by Government to evaluate the operation of any reform against key objects, including the reduction and elimination on the use of restrictive practices. The timing of such a review must allow enough time for any changes to have an effect, and for data to be collated, for example, 5 years.

#### **Recommendation 21:** A commitment to evaluate against key objects, including the reduction and elimination of the use of restrictive practices, must be built into any reform, allowing sufficient time for changes to have effect and data to be collected.

1. Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships, *Reforming Queensland’s Authorisation Framework for the Use of Restrictive Practices in NDIS and Particular Disability Service Settings: Options for Reshaping Part 6 of the Disability Services Act 2006* [Nov 2021] (‘*Consultation Paper’*). [↑](#footnote-ref-1)
2. Policy Innovation Hub, Griffith University, *Final report: Independent Review of Queensland’s Regulatory Framework for Positive Behaviour Support and Restrictive Practices* (November 2020) (‘*Independent Review’*). [↑](#footnote-ref-2)
3. *Human Rights Act 2019* (Qld) s 48(3). [↑](#footnote-ref-3)
4. Phillip French, *Human Rights Indicators for People with Disability: a Resource for Disability Activists and Policy Makers* (Queensland Advocacy Incorporated, 2008) 12. [↑](#footnote-ref-4)
5. *National Disability Insurance Scheme Act 2013* (Cth) s 181H(f). [↑](#footnote-ref-5)
6. *Owen-D’Arcy v Chief Executive, Queensland Corrective Services* [2021] QSC 273 [108]-[109], [131]. [↑](#footnote-ref-6)
7. Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Overview of Responses to the Restrictive Practices Issues Paper* (Overview report, April 2021) 8 (‘*Disability Royal Commission Restrictive Practices Issues Paper Responses’*). [↑](#footnote-ref-7)
8. *Disability Royal Commission Restrictive Practices Issues Paper Responses* (n 7) 7. [↑](#footnote-ref-8)
9. Queensland Productivity Commission, *Final Report: The NDIS Market in Queensland* (April 2021) 406 (‘*NDIS Market in Queensland report*’). [↑](#footnote-ref-9)
10. *Disability Royal Commission Restrictive Practices Issues Paper Responses* (n 7) 7. [↑](#footnote-ref-10)
11. *Consultation paper* (n 1) 2. [↑](#footnote-ref-11)
12. *Human Rights Act 2019* (Qld) s 58. [↑](#footnote-ref-12)
13. See *Human Rights Act 2019* (Qld) s 9. [↑](#footnote-ref-13)
14. *Consultation Paper* (n 1) 6–7. [↑](#footnote-ref-14)
15. As summarised in the *Independent Review* (n 2) 14. [↑](#footnote-ref-15)
16. *Disability Royal Commission Restrictive Practices Issues Paper Responses* (n 7) 4. [↑](#footnote-ref-16)
17. For example, a forensic disability client may receive services involving restrictive practices from both the Forensic Disability Service, which is governed by the *Forensic Disability Services Act 2011* (Qld), and from an NDIS service provider when undertaking community treatment: *Forensic Disability Act 2011* (Qld) s 47. [↑](#footnote-ref-17)
18. *Disability Services Act 2006* (Qld) s 146. [↑](#footnote-ref-18)
19. *Disability Services Act* *2006* (Qld) s 144. [↑](#footnote-ref-19)
20. *Consultation Paper* (n 1) 14. [↑](#footnote-ref-20)
21. NDIS Quality and Safeguards Commission*, Regulated Restrictive Practices Guide* (the Commission, version1.1, October 2020) 14. [↑](#footnote-ref-21)
22. *Callanan v Attendee Z* [2014] 2 Qd R 11, [33]-[37]. [↑](#footnote-ref-22)
23. United Nations Office of the High Commissioner for Human Rights, *CCPR General Comment 20: Article 7 (Prohibition of Torture, or Other Cruel, Inhuman or Degrading Treatment or Punishment)*, 44th sess, (10 March 1992) [6]. [↑](#footnote-ref-23)
24. United Nations Human Rights Committee, *Consideration of Reports Submitted by States Parties under Article 40 of the Covenant: Concluding Observations of the Human Rights Committee: Denmark*, UN Doc CCPR/CO/70/DNK (15 November 2000) 3 [12]. [↑](#footnote-ref-24)
25. *Consultation Paper* (n 1) 10. [↑](#footnote-ref-25)
26. Ibid 16. [↑](#footnote-ref-26)
27. In May 2020, the media reported 66,999 reports of unauthorised restrictive practices made to the NDIS Quality and Safeguards Commission over an 18-month period. See: Luke Henriques-Gomes, ‘NDIS Providers Used Unauthorised Restraints More Than 65,000 Times Watchdog Reports’, *The Guardian* (online, 27 May 2020) <https://www.theguardian.com/australia-news/2020/may/27/ndis-providers-used-unauthorised-restraints-more-than-65000-times-watchdog-reports>. [↑](#footnote-ref-27)
28. *Disability Services Act 2006* (Qld) s 150. [↑](#footnote-ref-28)
29. Respite/community access plans might still be required. For requirements to development respite/community access plans, see *Disability Services Act 2006* (Qld) s 181. [↑](#footnote-ref-29)
30. This is generally reflective of s 156(3) of the *Disability Services Act 2006* (Qld) and who the chief executive of Disability Services must consult before deciding whether a multidisciplinary assessment of the adult will be conducted. [↑](#footnote-ref-30)
31. *Guardianship and Administration Act 2000* (Qld) s 80V, s 80ZD. [↑](#footnote-ref-31)
32. Office of the Public Advocate, *Improving the Regulation of Restrictive Practices in Queensland: a Way Forward* (Reform Options Paper, 5 October 2021) 3 <<https://www.justice.qld.gov.au/__data/assets/pdf_file/0004/697729/20211005-opa-restrictive-practices-reform-options-paper.pdf>>. [↑](#footnote-ref-32)
33. *Consultation Paper* (n 1) 20. [↑](#footnote-ref-33)
34. *Disability Royal Commission Restrictive Practices Issues Paper Responses* (n 7) 12. [↑](#footnote-ref-34)
35. *Consultation Paper* (n 1) 23. [↑](#footnote-ref-35)
36. *Child Protection Act 1999* (Qld) s 99H. [↑](#footnote-ref-36)
37. Based on a search of the Commission’s complaints database for complaints received between 1 January 2020 and 10 February 2022 for the words ‘service provider’ or ‘NDIS’ contained in the allegation summary. [↑](#footnote-ref-37)
38. *Human Rights Act 2019* (Qld) s 88(4). [↑](#footnote-ref-38)
39. *NDIS Market in Queensland report* (n 9) xxi. [↑](#footnote-ref-39)
40. ‘Retention of this power provides the necessary flexibility if required to support the market as it continues to develop in response to the transition to the NDIS’: *Consultation Paper* (n 1) 9-10. Note: the *Disability Services Regulation 2017* (Qld) currently only excludes from regulation service providers covered by the *Aged Care Quality and Safety Commission Act 2018* (Cth). [↑](#footnote-ref-40)
41. *Re Beth* (2013) 42 VR 124 [185]; [2013] VSC 189. [↑](#footnote-ref-41)
42. Ibid [186]-[195]. [↑](#footnote-ref-42)
43. *Mental Health Act 2016* (Qld) s 740. [↑](#footnote-ref-43)
44. Law Council of Australia, *Australian Solicitor Conduct Rules* (24 August 2015) 8.1. [↑](#footnote-ref-44)
45. *Queensland Capacity Assessment Guidelines 2020: a Guide to Understanding Capacity, Capacity Assessment and the Legal Tests of Capacity under Queensland’s Guardianship Legislation* (version 2, effective 7 April 2021). The Guidelines are made under the *Guardianship* *and Administration Act 2000* (Qld) s 250. [↑](#footnote-ref-45)
46. *Mental Health Act 2016* (Qld) s 739(3). [↑](#footnote-ref-46)
47. See United Nations Office of the High Commissioner for Human Rights, *CCPR General Comment No 16: Article 17 (Right to Privacy)*, 32nd sess, (8 April 1988) 10. [↑](#footnote-ref-47)
48. *Disability Royal Commission Restrictive Practices Issues Paper Responses* (n 7) 7. [↑](#footnote-ref-48)
49. *Independent Review* (n 2) 6. [↑](#footnote-ref-49)