Reforming Queensland's authorisation framework for the use of Restrictive Practices

Submission by

Queensland Advocacy Incorporated

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

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About Queensland Advocacy Incorporated

Queensland Advocacy Incorporated (**QAI**) is an independent, community-based advocacy organisation and community legal service that provides individual and systems advocacy for people with disability. Our mission is to advocate for the protection and advancement of the fundamental needs, rights and lives of people with disability in Queensland. QAI's Management Committee is comprised of a majority of persons with disability, whose wisdom and lived experience is our foundation and guide.

QAI has been engaged in systems advocacy for over thirty years, advocating for change through campaigns directed at attitudinal, law and policy reform. QAI has also supported the development of a range of advocacy initiatives in this state. For over a decade, QAI has provided highly in-demand individual advocacy services. These services are currently provided through our three advocacy practices: the Human Rights Advocacy Practice (which provides legal advocacy in the areas of guardianship and administration, disability discrimination and human rights law, non-legal advocacy support with the Disability Royal Commission, the justice interface and education, and social work services); the Mental Health Advocacy Practice (which supports people receiving involuntary treatment for mental illness); and the NDIS Advocacy Practice (which provides support for people challenging decisions of the National Disability Insurance Agency and decision support to access the NDIS). Our individual advocacy experience informs our understanding and prioritisation of systemic advocacy issues.

QAI's recommendations

1. Reforming Queensland's authorisation framework needs to be part of a larger piece of work designed to reduce and eliminate the use of restrictive practices on people with disability.

2. Expand the scope of Queensland's restrictive practices authorisation framework to include all NDIS participants, including children with disability and persons with disabilities other than intellectual or cognitive disability.

3. Restrictive practices used on *all* people with disability in *every* setting in which they occur, including schools, aged care facilities and detention settings, must be regulated and monitored.

4. Align Queensland's restrictive practice definitions with those in the NDIS Rules. Ensure that locking gates, doors, and windows to prevent physical harm being caused to an adult with a skills deficit is considered a restrictive practice for the purposes of the legislation.

5. Consider additional procedural safeguards for containment as a type of 'environmental restraint', owing to the gravity of this type of restrictive practice. For example, approval from a higher-level authorisation officer could be required, together with increased oversight of its use.

6. Strengthen the definition of environmental restraint in both the NDIS rules and in Queensland's authorisation framework, with greater detail and more nuance to clearly demonstrate the differing levels of restrictive practices encompassed by this overarching definition.

7. Expressly prohibit certain forms of restrictive practices in Queensland's legislation, including the use of seclusion and containment for children under 18, the use of physical restraints such as prone and supine restraint and the use of psychosocial restraints that exert emotional and psychological control over people with disability.

8. Introduce an administrative model of authorisation, whereby a Senior Practitioner undertakes functions such as providing authorisation for restrictive practices, providing advice, developing guidelines and building the capacity of the sector.

9. QAI does *not* support the proposal for Authorised Program Officers or panels located within service providers and/or appointed by service providers to authorise the use of *any* restrictive practices.

10. QAI does *not* support removing the ability of the Department of Disability Services to develop positive behaviour support plans for the use of containment and/or seclusion. The Queensland government must remain a provider of last resort indefinitely, owing to its non-derogable responsibility to protect its most vulnerable citizens from harm.

11. All decisions should be reviewable by QCAT, with all persons with disability provided access to an independent disability advocate or legal representative depending upon the practice used.

12. The team working alongside the Senior Practitioner should include people with lived experience of disability and restrictive practices.

13. Facilitate greater active participation of people with disability in the authorisation process. This will require the injection of additional resources to ensure measures are not tokenistic.

14. Ensure access to independent disability advocacy to help ensure the will, preferences, and rights of people with disability remain central to decision-making regarding the use of restrictive practices

Introduction

QAI welcomes the opportunity to provide feedback on reforming Queensland's authorisation framework for the use of restrictive practices. QAI considers the use of restrictive practices to infringe the fundamental human rights of people with disability. Restrictive practices are used as a form of behaviour control, applied to individuals considered to be exhibiting 'behaviours of concern'. There are numerous issues with this, not least the assumption that the problem lies with the individual rather than the systems that control them, and that the solution lies with a restriction of personal freedoms as opposed to structural change.

QAI agrees that Queensland's current authorisation framework falls short of the principles for nationally consistent restrictive practices authorisation arrangements. We agree that the framework must apply to *all* people with disability, address potential conflicts of interest, provide for administrative review of all decisions and be simple and easy to navigate. Accordingly, QAI supports many of the proposed ideas for reform discussed in the consultation paper and the increasing recognition of the need to ensure adequate human rights protection to people subjected to the use of restrictive practices.

However, QAI has strong reservations regarding the proposed role of Authorised Program Officers and their proposed relationship with disability service providers. The market-based nature of the National Disability Insurance Scheme ('NDIS') means that service providers are free to make decisions to suit their own interests, even when this is not in alignment with the interests of participants. Allowing service providers to choose and 'appoint Authorised Program Officers' to obtain approval for the use restrictive practices on their clients

essentially enables service providers to sanction the use of restrictive practices through mutually beneficial business arrangements. This creates the very conflict of interest that states and territories are urged to avoid.

Despite policies typically declaring an intention to reduce or eliminate the use of restrictive practices, this is rarely achieved in practice. The current review of Queensland's authorisation framework is therefore a timely opportunity to ensure both procedural *and* substantive safeguards exist to enable this vital policy objective to be realised. Whilst improving the authorisation process is an essential first step, it alone will not be sufficient and must be considered as part of a larger piece of work that is required to overhaul the use of restrictive practices on people with disability in *every* setting in which they occur, including schools, aged care facilities and detention settings. Whichever authorisation model is ultimately chosen, inadequate funding for positive behaviour support plans and insufficient oversight by the NDIS Quality and Safeguards Commission continue to constitute significant barriers for Queenslanders with disability seeking to uphold their newly legislated human rights.[1] These issues must also receive urgent policy attention and become the subject of meaningful consultation with the disability community.

QAI's submission will address each of the proposed ideas for a new authorisation framework in turn.

1. Expanding the scope of Queensland's restrictive practice authorisation process to include all NDIS participants

QAI supports expanding the scope of Queensland's restrictive practices authorisation framework to include all NDIS participants, including children with disability and persons with disabilities other than intellectual or cognitive disability. QAI considers the current piecemeal coverage of the *Disability Services Act 2006* (Qld) ('DSA') to be inherently problematic, with the result that some people with disability have their freedoms limited yet cannot equitably access critical human rights protections provided by legislation. For example, research has shown that older adults with psychosocial disability are at a higher risk of being subjected to restrictive practices. The Citizens Committee on Human Rights found that mentally ill elderly South Australians had been physical restrained or held in isolation more than patients of any other age group.[2]

Greater alignment with other Australian jurisdictions as well as NDIS rules that require service providers to register restrictive practices used on children with disability and adults with disabilities other than intellectual or cognitive disabilities, would be welcome. Expanding the definition to include children and people with disabilities other than intellectual or cognitive disabilities will also help to create attitudinal change by setting an expectation that anyone who is subjected to such restraints in the context of disability service provision is entitled to the same legislative safeguards.

However, QAI considers that the DSA should go further and expand the authorisation process to include ***all*** people with disability who are subjected to restrictive practices in ***every*** setting in which they occur. Restrictive practices are used in all corners of society and in any context in which a person with disability is perceived to exhibit a 'behaviour of concern' that purportedly poses a threat to the safety of the person or others. This includes in the home, at school, in mental health facilities, in prisons and in residential facilities. The use of

[1] As per the *Human Rights Act 2019* (Qld)

[2] Citizens Committee on Human Rights: The Mental Health Watchdog, *Restraint Is Criminal* (2020) https://cchr.org.au/restraint-is-criminal.

restrictive practices on children with disability in educational settings is of particular concern to QAI. Through our Education Advocacy Service, QAI has provided individual advocacy for children within the state education system who have been subjected to restrictive practices such as being locked in cupboards, separated from their peers or physically manhandled. Such practices currently occur at the unfettered discretion of school Principals, without regulation or independent oversight. By the time the Regional Office becomes involved via a complaints process, the student has typically suffered significant harm and been denied access to critical learning opportunities. These practices must therefore carry the same level of independent authorisation that children with disability subjected to restrictive practices in the context of disability service provision, receive.

2. Align Queensland's restrictive practice definitions with those in the *NDIS (Restrictive Practice and Behaviour Support) Rules 2018* (Cth)

QAI notes the variation in restrictive practice definitions and the confusion that this disparity creates. QAI considers that an effective conversation about reducing or eliminating restrictive practices can only occur when there is semantic consensus and a nationally consistent approach to defining restrictive practices at the legislative, policy and operational levels. As such, QAI supports aligning Queensland's restrictive practice definitions with those in the NDIS Rules. This would ensure that locking gates, doors, and windows to prevent physical harm being caused to an adult with a skills deficit would be considered a restrictive practice for the purposes of the legislation, an outcome QAI wholeheartedly supports. Whether or not an adult is deemed to have a 'skills deficit', for example because they are considered 'vulnerable to abuse or exploitation by others'[3] is very subjective and highly susceptible to the paternalistic attitudes of well-meaning yet inadequately trained support workers. The locking of gates, doors, and windows constitutes a significant human rights infringement and service providers should therefore seek authorisation for its use in all circumstances. Further, this authorisation should come from a skilled clinician who is trained in human rights discourse, the social model of disability and the myriad factors that influence the use of restrictive practices, such as prejudicial attitudes, a lack of understanding of the person and/or their disability, and organisational and resource constraints.

However, QAI considers that additional procedural safeguards are required for containment as a type of 'environmental restraint', owing to the gravity of this type of restrictive practice and the significant impact it has upon a person's liberty in contrast to other types of environmental restraint, such as restricted access to objects. For example, approval from a higher-level authorisation officer could be required, together with increased oversight of its use. Accordingly, the definition of environmental restraint in both the NDIS rules and in Queensland's authorisation framework could be strengthened with greater detail and more nuance to clearly demonstrate the differing levels of restrictive practices encompassed by this overarching definition. For example, there could be different categories of environmental restraint, such as level 1, 2 or 3; or 'environmental restraint – containment', 'environmental restraint – restricted access to objects' etc could be used alternatively, following consultation with other states and territories and subsequent modification to the NDIS rules.

[3] *Disability Services Act 2006* (Qld), s217(b)

3. Expressly prohibit certain forms of restrictive practices

QAI supports expressly prohibiting certain forms of restrictive practices in Queensland's legislation. Restrictive practices constitute some of the most grave human rights violations and our experience tells us that misunderstandings regarding what constitutes a restrictive practice are widespread within the community. Explicitly listing certain practices as prohibited would therefore help to educate the sector and would provide a clear expectation regarding what conduct is completely unacceptable, regardless of the circumstances. This could include a list of restrictive practices which are not appropriate for adults, as well as those that are inappropriate for children. QAI recommends that containment and seclusion be prohibited in all circumstances for children under the age of 18.

QAI supports the recommendation of the Griffith Review which stated:

"At a minimum this list should include:

- *all the forms of physical restraint as prohibited by the Victorian Senior Practitioner: prone restraint, supine restraint, pin downs, take down techniques and any technique that interferes with respiration or digestion, pushed a person's head towards their chest and physical restraints that inflict pain and hyperextension of joints or pressure on joints or chest*
- *the prohibitions contained in the NSW Restrictive Practices Authorisation Policy (v2.0), which includes aversion, over-correction, misuse of medication and denial of key needs."*[4]

QAI also recommends the following practices are listed as prohibited restrictive practices:

- constant and intensive supervision or not ensuring an accessible environment;[5]
- forcing a person to wear clothing specifically designed to impede behaviours of concern;[6]
- employing psychosocial techniques which can impact a person's exercise and choice and self-determination; i.e. psychosocial restraint, which is 'the use of inter-personal interactions, which might reasonably be construed by the person to whom they are directed as intimidating or aversive, and/or threats of social or other sanctions which rely upon eliciting fear to moderate a person's behaviour'[7];
- explicit restrictions on where a person lives, who they live with, how they spend their time, access to personal monies, their right to access the local community, their right to sexual expression, and their right to privacy.[8]

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[4] Griffith University (2020) *Final Report: Independent review of Queensland's regulatory framework for positive behaviour support and restrictive practices*; https://qchub.dsdsatsip.qld.gov.au/app/webroot/js/admin_js/kcfinder/upload/queenslandcommunities/files/PBSRP_IndependentReview.pdf; page 8

[5] Active Social Care Limited, *Restrictive Practices* (ND) https://activesocialcare.com/handbook/safeguarding-adults/restrictive-practices

[6] Adelaide Night and Day Family Therapy, *Tied Up in Knots: Systemics, Occupational Therapy and Restrictive Practices* (April 2011) https://adelaidetherapy.com/tied-up-in-knots-systemics-occupational-therapy-and-restrictive-practices/.

[7] McVilly, K (2009) *Physical Restraint in Disability Services: Current Practices, Contemporary Concerns and Future Directions*. Melbourne, Victoria: The Office of the Senior Practitioner, Department of Human Services.

[8] KARE Policy, *Restraint/Restrictive Practices Policy* (May 2018) http://www.fedvol.ie/_fileupload/Quality%20&%20Standards/Additional%20Policies%202018/KARE/Restraint%20Restrictive%20Practices%20Policy.pdf

These 'softer' methods of exerting control can be equally restrictive and destructive of a person's self-determination and must therefore be prohibited.[9] Further, the legislation should include a provision that explains the list is a non-exhaustive list of practices that are not permitted by law.

4. More streamlined authorisation process for restrictive practices

QAI supports streamlining Queensland's authorisation process for restrictive practices and replacing the convoluted procedures currently in place. QAI agrees that having a single point of accountability for authorisation decisions would be an improvement and would enable quicker access to justice for people with disability whose human rights are limited by their service providers. The system must be easy to understand, so people with disability readily know their rights and providers are not unduly delayed in their reporting obligations. As such, QAI supports the idea of an administrative model of authorisation, whereby a Senior Practitioner undertakes functions such as providing authorisation for restrictive practices, providing advice, developing guidelines and building the capacity of the sector e.g. through training and research. Authorising the use of restrictive practices requires sophisticated clinical judgement and a consistent approach, both of which could be facilitated by this new model.

However, QAI does not support the proposal for Authorised Program Officers or panels located within service providers and/or appointed by service providers to authorise the use of *any* restrictive practices. The responsibility to assess whether a restrictive practice is required and provide authorisation for its use must remain with government officials who are accountable to Parliament. This responsibility should not be contracted out to entities located within and/or affiliated with service providers due to the considerable risk of conflicting interests. If the overriding objective is truly to reduce or eliminate the use of restrictive practices, they must never be authorised by an entity, such as a service provider or person affiliated with a service provider, who potentially stands to gain from their use. It is well documented that restrictive practices are often used due to a myriad of factors, many of which do not necessarily stem from the individual concerned. Sometimes they occur as a result of poor-quality service provision where a service provider has failed to take the time to properly understand the individual, their history, any triggers for particular behaviours and any appropriate strategies. Such efforts take time and money and therefore represent a cost to the service provider who consequently lack a financial incentive to avoid the use of restrictive practices. The very act of then 'appointing an Authorised Program Officer' to authorise the use of restrictive practices risks mutually beneficial business relationships influencing the decision-making of the Authorised Program Officer. Further, the introduction of an 'independent person' to explain, among other things, the proposed use of restrictive practices to the individual, would not be a sufficient safeguard. This is because of the power imbalance between service providers and a participant's informal supports (who are likely to fulfil the role of an 'independent person') due to the market-based scheme where sourcing disability services has become the responsibility of the participant and their families as opposed to the government.

For similar reasons, QAI does not support removing the ability of the Department of Disability Services to develop positive behaviour support plans for the use of containment and/or seclusion. It is one thing to remove the government's statutory monopoly on the preparation of positive behaviour support plans for seclusion and containment, but it is another entirely to withdraw as a provider of last resort. While we

[9] McVilly, K (2019) *Psycho-social restraint: An unacknowledged cruel, inhuman and degrading restrictive practice in disability services: brief report*; International Journal of Positive Behaviour Support, 9, 2, 41-45

acknowledge the rationale to remove this function is to allow for greater 'choice and control' through the utilisation of the NDIS market, QAI considers that the market will never be ready to solely take on this function owing simply to the inherent nature of a market-based scheme. That is, a scheme whereby participants and service providers are free to make decisions in accordance with their own (sometimes competing) interests. Safeguards designed to protect people's human rights should not be compromised for the sake of market development and economic growth.

The grave nature of the limitations imposed by seclusion and containment require a safety net that the free operation of the NDIS market will simply never provide. People with disability subjected to such practices require a level of certainty that they can access positive behaviour support plans from a government provider if and when the market cannot provide one. In QAI's experience, participants with complex needs (who are more likely to be subjected to restrictive practices) often experience difficulties accessing supports as service providers have been known to terminate service agreements when challenges arise. Providers can cease to exist or make decisions based upon revenue and the intensity of resources required to support a particular individual. They can turn clients away, particularly in an under-developed area of the market such as providing positive behaviour support plans. This can leave vulnerable participants with complex needs without positive behaviour support plans that regulate the use of restrictive practices. This will increase if the Queensland government withdraws as a provider of last resort and arguably puts people with disability into a situation that far surpasses the original intentions of the NDIS.

Removing the responsibility of developing positive behaviour support plans from the Department also mistakenly assumes that participants have sufficient funding in their plan to access positive behaviour support plans from NDIS service providers, and have ready access to high quality providers, both of which are unfortunately not a reality. Since the introduction of the NDIS, QAI has observed numerous participants having insufficient funding for positive behaviour support plans and having to initiate lengthy review processes to obtain increased funding. QAI has also found a marked decline in the quality of positive behaviour support plans. There is a lack of experience among practitioners and a lack of innovation in positive behaviour support plans leading to an increasing use of generic plans that are not tailored to the individual's needs. This means that people with disability are having their freedoms limited in the absence of evidence-based guidance that will successfully address the behaviour of concern and reduce or eliminate the need for the restrictive practice. Further, the broader remit of the NDIS Restrictive Practice rules has led to an increased demand for positive behaviour support plans, yet insufficient registered service providers capable of providing them are available, particularly in rural and remote parts of Queensland. Whilst some of these issues can and theoretically should improve, it will not take away the ability of service providers to terminate agreements and cease supporting participants due to their own prevailing interests.

Moreover, recent statistics from the NDIS Quality and Safeguards Commission's Activity Report showed that there were 1,032,064 incidents of unauthorised restrictive practices for the 12-month period between June 2020 and June 2021.[10] This is a staggering figure which, together with the aforementioned issues, highlights a market that has struggled with the transition to the NDIS and which is unprepared for the move towards privatising the preparation of positive behaviour support plans. The current inability of the Quality and Safeguards Commission to respond to participant complaints in a timely manner is also cause for concern. Though it has been suggested the government would delay absolving this responsibility until such time that

[10] NDIS Quality and Safeguards Commission (2021) *Activity Report: 1 July 2020 to 30 June 2021*; https://www.ndiscommission.gov.au/sites/default/files/documents/2021-09/210907-activity-report-fy20-21.pdf

the market has 'developed sufficiently', QAI urges the Queensland government to remain a provider of last resort indefinitely owing to its non-derogable responsibility to protect its most vulnerable citizens from harm. While the NDIS is indeed a market-based scheme, it is not a market of goods and chattels, but a market that centres around the lives and rights of people with disability.

QAI therefore supports a more streamlined authorisation process, such as the adoption of a Senior Practitioner who could authorise the use of all restrictive practices. They could oversee a team of highly trained and expert officials, some of which may be assigned higher or lower levels of responsibility to authorise the use of certain restrictive practices, commensurate with their levels of experience and expertise. The Senior Practitioner themselves could retain responsibility to authorise certain practices such as seclusion and containment, and could review decisions every 3 months to ensure providers are actively working towards reducing and eliminating the use of restrictive practices. The Senior Practitioner would need to work collaboratively with the Quality and Safeguards Commission and could potentially utilise information regarding the level of compliance with a positive behaviour support plan by an NDIS service provider to inform the Senior Practitioner's authorisation decisions. Furthermore, there could be penalties issued to service providers who fail to comply with positive behaviour support plans, as well as mandatory training for those unable to demonstrate reduced or eliminated restrictive practices over time. This would help to increase the accountability of service providers implementing restrictive practices and would facilitate a greater focus on positive *outcomes* for people with disability, as opposed to processes alone.

The team working alongside the Senior Practitioner should also include people with lived experience of disability and restrictive practices. Statistics reveal that autism is the primary disability of 40% of persons receiving positive behaviour support plans; lived experience of people with autism would therefore add great value to the insights and approach of the Senior Practitioner and their team.

5. QCAT to review administrative decisions only

QAI supports changing the role of the Queensland Civil and Administrative Tribunal ('QCAT') with regards to restrictive practices, removing its authorisation responsibilities and enhancing its scope to administratively review all decisions of those empowered to authorise the use of restrictive practices. It is critical that decisions to authorise the use of restrictive practices are transparent, appealable, and accountable, given the significance of these decisions and their impact on the lives of the most vulnerable people with disability in our community. This would help to create a more streamlined and consistent approach to the use of restrictive practices and would better utilise the expertise and resources of QCAT's tribunal members.

Thus, QAI supports permitting all relevant persons to apply to QCAT for a review of a decision made under Queensland's authorisation framework. However, QAI does *not* support the legislation permitting service providers to apply to QCAT for a review of a decision to appoint, refuse the application of, or revoke the appointment of an Authorised Program Officer or similar role, owing to our concerns regarding the proposed role of Authorised Program Officers as expressed above. QAI considers that authorising the use restrictive practices is a responsibility that must remain with an independent party with expertise, informed by lived experience. It must not be contracted out to Authorised Program Officers who are able to be selected by service providers. These are significant liberty restrictions that must only ever be sanctioned as a last resort measure.

6. Facilitate greater active participation of people with disability in the authorisation and use of restrictive practices

QAI strongly urges the new authorisation framework to facilitate greater active participation of people with disability in all decisions around their own lives. There must be a presumption of capacity and a supported decision-making approach for all people with disability, in which a person is supported to exercise their autonomy and maintain their legal capacity through assisted decision-making. Not only would this decrease the incidence of communicative behaviours that can lead to the utilisation of restrictive practices in the first place, it would also enhance the prospects of restrictive practices being reduced and eliminated over time.

QAI considers that all persons with disability subjected to restrictive practices should be consulted with and actively involved during the authorisation process. This may involve supporting the person to consult with their informal supports to enhance their understanding and ability to engage in these critical conversations. It may also involve ensuring the person has access to appropriate communication aids or relevant cultural supports. These conversations must always begin with exploring, trying, and exhausting alternatives to the use of restrictive practices. As per the literature on best practice supported decision-making, "the will, preferences and rights of people with disability must direct the decisions that affect their lives".[11] However the views, wishes and preferences of the individual must not be incorporated in a tokenistic manner. For example, in Victoria, an Authorised Program Officer must ensure that an 'independent person' is available to explain to an NDIS participant the proposed application of restrictive practices and the individual's rights to review. However, this will unlikely be sufficient to ensure the views and preferences of the person remain central to decision-making, given the power imbalance between service providers and an adult's informal supports (who are likely to perform the role of an 'independent person'). This is because of the market-based nature of the scheme, whereby access to disability services is the responsibility of people with disability and their families, rather than the government. Further, some people with disability will not have access to an informal support person who could fulfil this role.

Access to independent disability advocacy should be incorporated into the authorisation framework to help ensure the will, preferences, and rights of people with disability remain central to decision-making regarding the use of restrictive practices. This could include access to legal representation when an application to review a decision to use restrictive practices is reviewed by QCAT, in a model similar to the provision of free, independent legal representation for persons subjected to certain orders by the Mental Health Review Tribunal. Access to NDIS support coordination funding could also be adopted as a safeguard for participants who are subjected to restrictive practices. This could occur alongside measures that prevent conflicts of interests from occurring, for example when disability service providers engage certain organisations to prepare positive behaviour support plans for their clients in return for referrals to their own service. Ultimately, ensuring greater participation of people with disability in the authorisation process will require increased resources if it is to be meaningful and not tokenistic.

7. Senior Practitioner must publish data on the performance of their functions

Should the role of Senior Practitioner be adopted, QAI supports the requirement for the Senior Practitioner to regularly publish information on the performance of their functions. Due to existing inadequacies in reporting

[11] Australian Law Reform Commission (2014) *Equality, Capacity and Disability in Commonwealth Laws*, p 11

and monitoring practices, together with variable definitions of restrictive practices across jurisdictions and between service systems, the true prevalence of restrictive practices is unknown. Without accurate and comprehensive data that demonstrates the prevalence of restrictive practices and the trends in their usage, strategies designed to reduce or eliminate restrictive practices will remain elusive. The data collected must be sophisticated and should include more than the number and types of restrictive practices used. It should also include qualitative information from people with disability who are subjected to restrictive practices[12] as well as information on the implementation of, and levels of compliance with, positive behaviour support plans by service providers to track whether restrictive practices are being successfully reduced or eliminated over time. The Senior Practitioner could impose an onus on providers to demonstrate strategies in a positive behaviour support plan have been implemented and where not evident, order mandatory training or a change in provider. Further, the Senior Practitioner (or similar role) should work closely with the NDIS Quality and Safeguards Commission to ensure a comprehensive picture of the occurrence of restrictive practices is captured, encompassing both the authorisation processes as well as the monitoring and oversight functions of the Commission.

Conclusion

QAI thanks the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships for the opportunity to contribute to this inquiry. QAI is happy to provide further information or clarification of any of the matters raised in this submission upon request. QAI also consents to the publication of this submission on the Department's website and/or aspects of this submission to be referenced in subsequent publications.

[12] As per Dr Spivakovsky, Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Transcript* (December 2019) https://disability.royalcommission.gov.au/publications/transcript-3-december-2019; p 24