

Frequently asked questions

Positive behaviour support and the use of restrictive practices; Amendments to the *Disability Services Act 2006*

Introduction

This document should be read in conjunction with the *Glossary* available on the Department of Communities, Disability Services and Seniors website

<https://www.communities.qld.gov.au/disability/key-projects/positive-behaviour-support>

The *Glossary* outlines terms commonly used within the Positive Behaviour Support: legislation, information and resources page and includes definitions of each type of restrictive practice.

Families of an adult with an intellectual or cognitive disability should first consult the publication *A guide for families: Positive behaviour support and the use of restrictive practices*, also available on the Department of Communities, Disability Services and Seniors website

<https://www.communities.qld.gov.au/disability/key-projects/positive-behaviour-support>

The information contained in this document is provided as a guide only. It is not intended to be, and is not a substitute for legal advice. Service providers should seek their own independent legal advice with reference to the implementation of the legislation

QUESTIONS

SCOPE OF THE LEGISLATION	2
1. How will the rights of individuals (including basic human rights) be safeguarded under the legislation?	2
2. Why do we have legislation?.....	3
3. How does the Act protect against abuse?.....	3
5. Where can I access a copy of the Disability Services Act 2006?	4
6. Where can I access a copy of the Carter Report and the government’s response to Judge Carter’s recommendations?	4
TO WHOM DOES THE LEGISLATION APPLY?.....	4
7. Given this legislation only applies to adults with an intellectual or cognitive disability receiving services provided or funded by Disability Services, or services prescribed by regulation and funded under a NDIS participant plan, how are adults protected in other settings?.....	4
8. Are adults with an intellectual or cognitive disability residing in hostels and boarding houses protected by the Act?.....	4
9. Does the Act apply to people under the age of 18?	5
10. Is psychological or financial harm included within the scope of the legislation?.....	5
GENERAL REQUIREMENTS OF THE LEGISLATION	5
11. If containment is considered to be a restrictive practice, why is the practice of locking the gates, doors and windows to a person’s house to impede their exit not considered to be a restrictive practice under this Act?..	5
12. How does the Act maximise opportunity for positive outcomes and reduce or eliminate the need for restrictive practices?	6
14. What are the requirements under the legislation for the safe transportation of adults?	7
15. How is this legislation monitored to ensure that plans are being implemented as approved?	7

16.	<i>Is there transparency and accountability for the scheme across disability services?</i>	7
17.	<i>How is the medical practitioner involved in decisions about the use of chemical restraint?</i>	8
18.	<i>Does chemical restraint include medication used to treat a mental illness or physical condition?</i>	8
19.	<i>Why are there different provisions for chemical restraint (fixed dose) in respite?</i>	8
20.	<i>Will there be safeguards to ensure that positive strategies are tried before a restrictive practice is suggested?</i>	9
21.	<i>Whose responsibility is it to undertake the assessment, develop the plan, and seek approval or consent from the relevant decision maker when there are two or more relevant service providers?</i>	9
22.	<i>Who must be consulted in the development of the positive behaviour support plan?</i>	9
23.	<i>How are families involved in the decision-making process?</i>	10
ASSESSMENT AND PLANNING		10
24.	<i>Who can undertake an assessment?</i>	10
25.	<i>What has to be covered in an assessment?</i>	11
26.	<i>What has to be included in a positive behaviour support plan?</i>	11
27.	<i>What has to be included in respite/community access plan?</i>	12
APPROVAL AND CONSENT.....		13
28.	<i>What is the difference between approval and consent?</i>	13
29.	<i>Who can be a guardian?</i>	13
30.	<i>Who makes the decision about containment or seclusion?</i>	13
31.	<i>Will authorisation to use restrictive practices be long- term or permanent?</i>	14
32.	<i>How are decisions of the Director- General of the Department of Communities, Disability Services and Seniors reviewed?</i>	14
33.	<i>How are QCAT decisions reviewed?</i>	15
RESOURCES TO THE SECTOR		15
34.	<i>How will the Department assist service providers to comply with the legislation?</i>	15
FURTHER INFORMATION.....		16

Scope of the legislation

1. How will the rights of individuals (including basic human rights) be safeguarded under the legislation?

Many decisions about the use of restrictive practices are approved and/or reviewed by the Queensland Civil and Administrative Tribunal (QCAT). QCAT is a specialist body with extensive experience in dealing with adults with impaired decision-making capacity. QCAT will only make decisions that are in the adult’s overall best interests.

The *Disability Services Act 2006* (the Act) states that when restrictive practices are proposed for such adults, they must be used in a way that:

- has regard for the human rights of those adults;
- safeguards them and others from harm;
- maximises the opportunity for positive outcomes and aims;
- reduces or eliminates the need for the use of the restrictive practice; and
- ensures transparency and accountability in the use of the restrictive practices.

Service providers must also demonstrate that the restrictive practice is only used when necessary to prevent harm to the adult or others, and is the least restrictive option for ensuring their safety. Service providers can demonstrate this by complying with the requirements outlined in the Act including the development of a positive behaviour support plan. The Act aims to

eliminate or reduce the use of restrictive practices and increase the adult's quality of life through positive behaviour support.

In addition, before any restrictive practices can be used, the Act generally requires:

- a positive behaviour support plan;
- the provision of a statement in the approved form about the proposed use of restrictive practices to the adult, their family members and others in their support network;
- an individual assessment of the adult;
- independent, time-limited approval; and
- plans for monitoring and review.

2. Why do we have legislation?

The purpose of the legislation is to strengthen safeguards and to uphold the human rights of adults with an intellectual or cognitive disability who exhibit challenging behaviour. In addition, the legislation regulates the use of restrictive practices and provides a positive behaviour support system to improve the quality of life of these adults.

The legislation ensures that any use of restrictive practices (for example, containment or seclusion) by a service provider has regard for the human rights of these adults, and is the least restrictive way of safeguarding them and others from harm. In addition, the legislation aims to reduce or eliminate the need for the use of restrictive practices across the disability services sector and helps ensure transparency and accountability.

3. How does the Act protect against abuse?

The Act states that adults with an intellectual or cognitive disability and challenging behaviour who are subject to restrictive practices will also be subject to monitoring safeguards, including:

- authorised officers appointed under the Act, who may investigate non-compliance.
- community visitors who are appointed to visit the adult's residence and help them understand their rights, protect the adult's interests and ensure nobody is taking advantage of the adult.
- a requirement under the Act for service providers to report on every instance of use of a restrictive practice.

4. Why are there immunities for service providers?

The immunity clause in the Act states that a service provider is not criminally or civilly liable if the service provider acts honestly and without negligence, and uses restrictive practices in compliance with the Act. It is a purpose of the Act to ensure that any use of restrictive practices is justifiable and in accordance with the provisions of the Act.

The Act includes immunities to help provide legal certainty to disability service providers and their staff on when restrictive practices may be justified and used lawfully. Restrictive practices used by disability service providers will only be lawful when all of the requirements in the Act are met.

5. Where can I access a copy of the *Disability Services Act 2006*?

The Act can be downloaded from the Queensland Legislation website
www.legislation.qld.gov.au

6. Where can I access a copy of the Carter Report and the government's response to Judge Carter's recommendations?

The Carter Report and the government's response to Judge Carter's recommendations are available on Centre of Excellence for Clinical Innovation and Behaviour Support website:

<http://www.communities.qld.gov.au/disability/key-projects/positive-behaviour-support/centre-of-excellence-for-clinical-innovation-and-behaviour-support>

To whom does the legislation apply?

7. Given this legislation only applies to adults with an intellectual or cognitive disability receiving services provided or funded by Disability Services, or services prescribed by regulation and funded under a NDIS participant plan, how are adults protected in other settings?

Any person with a disability continues to receive the full protection of existing criminal and civil laws.

That means anyone who acts improperly towards someone in their care (for example, by abuse, assault, neglect or exploitation) may be subject to criminal sanctions or may be ordered to pay compensation as a result of a civil law suit.

8. Are adults with an intellectual or cognitive disability residing in hostels and boarding houses protected by the Act?

Any resident support services, community support and community access services funded or provided by the Department of Communities, Disability Services and Seniors that provide services to residents of hostels and boarding houses are subject to this legislation.

The hostels and boarding houses that are not funded disability service providers are not subject to the requirements of this Act. However, other reforms to the private residential services sector regulate the quality of services in that sector.

The Act sets out service delivery principles outlining what is considered to be good practice behaviour support for adults with an intellectual or cognitive disability. It is hoped that all service providers, even those not funded or provided by Disability Services, will adopt the human rights and behaviour support principles outlined in the Act.

9. Does the Act apply to people under the age of 18?

Part 6 *Disability Services Act 2006* which regulated the use of restrictive practices and Chapter 5B of the *Guardianship and Administration Act 2000* only apply to adults who are 18 years or older.

There is a provision that allows for the appointment of a guardian for restrictive practice matters to be made in advance of an individual turning 18. This provision will have no effect until the person turns 18, and can only last until the person is 19 years before it must be reviewed. This provision will allow the Department of Communities, Disability Services and Seniors to prepare for situations, such as when they know that a person will be leaving the care of the Department of Child Safety, Youth and Women into supported accommodation provided by Disability Services.

10. Is psychological or financial harm included within the scope of the legislation?

The legislation defines harm to a person as:

- physical harm to the person;
- a serious risk of physical harm to the person; or
- damage to property involving a serious risk of physical harm to the person.

These provisions do not extend to psychological or financial harm. However, existing criminal or civil law that is in place to protect an individual's rights still apply. The intent of the legislation is to safeguard the adult or others from physical harm by ensuring that the practice used to manage the challenging behaviour is the least restrictive way of ensuring the adult's and others' safety.

General requirements of the legislation

11. If containment is considered to be a restrictive practice, why is the practice of locking the gates, doors and windows to a person's house to impede their exit not considered to be a restrictive practice under this Act?

The practice of locking gates, doors and windows is only permissible when it is being used to prevent physical harm being caused to an adult with a skills deficit. This means that the only reason for locking the gates, doors or windows is to protect the physical safety of an adult:

- where the adult lacks road safety skills;
- who is vulnerable to abuse or exploitation by others; or
- where the adult is unable to find his or her way back to the premises.

While this practice is not deemed to be a restrictive practice for the purposes of this Act, by including this practice in the Act, it allows the practice to be regulated to help ensure greater protection of an individual's rights and liberties.

Under the Act, service providers are authorised to use the practice of locking gates, doors and windows only if they keep and implement a policy on the practice which must be consistent with the Department's policy.

12. How does the Act maximise opportunity for positive outcomes and reduce or eliminate the need for restrictive practices?

The Act sets out principles to achieve positive outcomes for people with an intellectual or cognitive disability by stating service providers must always provide service that:

- promotes the adult's development and abilities;
- provides opportunities for participation and inclusion in the community;
- responds to the adult's needs and goals; and
- ensures the adult and their family and friends are given an opportunity to participate in the development of strategies for the care and support of the adult

If the use of restrictive practices is being considered as necessary to prevent harm to the adult or others and is the least restrictive option for ensuring their safety, the Act requires that the adult is assessed. For details of "What has to be covered in an assessment" see question 25.

For containment and seclusion an assessment must be completed by at least two people appropriately qualified or experienced in different fields. For physical, mechanical or chemical restraint one appropriately qualified or experienced person must complete the assessment.

The Act then requires that a positive behaviour support plan informed by the assessment is completed. The Act sets out what a positive behaviour support plan must include (See question 26 "What has to be covered in a positive behaviour support plan?").

The positive behaviour support plan is the vehicle through which positive strategies are implemented while seeking to reduce reliance on the use of restrictive practices. For service providers to receive immunity from liability under the Act, they must ensure that the positive strategies in the plan are implemented.

The Act also requires that all staff implementing the plan (including positive strategies and restrictive practices) have appropriate skills and knowledge for implementing these strategies.

13. Does the Act allow for a situation where an adult subjected to a restrictive practice under this scheme may also be subject to a forensic order or an involuntary treatment order under the *Mental Health Act 2000*?

Yes. The Act does allow for this and requires that when the service provider is aware that the adult is under a forensic or involuntary treatment order under the *Mental Health Act 2000*, the authorised psychiatrist responsible for the treatment of the adult under that Act is consulted and given the opportunity to participate in the development of the positive behaviour support plan.

For decisions made by a guardian for restrictive practice matters, the guardian must consider the views of the treating psychiatrist when deciding whether to give consent for the use of a restrictive practice.

For decisions made by QCAT, the Director of Mental Health, Queensland Health is an active party under the *Guardianship and Administration Act 2000* if the adult is subject to a forensic order or an involuntary treatment order under the *Mental Health Act 2000*. This means they are

notified of hearings before QCAT for that adult, and may attend, and make representations at, the hearing.

14. What are the requirements under the legislation for the safe transportation of adults?

The legislation says that using a device to enable the safe transportation of the adult does not fall under the definition of mechanical restraint and is therefore not a restrictive practice. The requirements outlined in the legislation do not apply in this case.

15. How is this legislation monitored to ensure that plans are being implemented as approved?

Regular review and monitoring are key requirements of the Act. All approvals are time-limited and must be reviewed regularly. Many decisions on the use of restrictive practices are subject to formal review by QCAT, which must occur at least once every 12 months. The Act also requires specific records to be kept on the use of restrictive practices.

Monitoring of the scheme is achieved by:

- authorised officers appointed under the *Disability Services Act 2006*;
- an investigative function for the Public Guardian under the *Guardianship and Administration Act 2000*, and/or
- an inquiry/complaint function for the Community Visitor Program under the *Guardianship and Administration Act 2000*.
- compliance with requirements to keep and implement acceptable restrictive practices policies will continue to be subject to rigorous and periodic third-party audits under the Human Services Quality Framework (HSQF).

In 2015 a regulation under the Act was introduced that requires service providers to report monthly on every instance of use of a restrictive practice. This reporting will help service providers better monitor the way they use restrictive practices and provide the Department with data to analyse how the restrictive practice framework is being implemented.

16. Is there transparency and accountability for the scheme across disability services?

Yes, transparency and accountability is achieved by:

- The Community Visitor Program which continues its existing inquiry/complaint function. It will monitor, inquire into and report on the use of restrictive practices at visitable sites where disability services are delivered;
- The requirements under the Act that the positive behaviour support plan includes information about observations and monitoring of the restrictive practice, and the intervals at which the restrictive practice will be reviewed;
- Legislating that authorisations for the use of restrictive practices is given by QCAT or by a guardian for restrictive practices is subject to regular review by QCAT;

- Ensuring that compliance with requirements to keep and implement acceptable restrictive practices policies will continue to be subject to rigorous and periodic third-party audits under the Human Services Quality Framework (HSQF); and
- The reporting regulation that compels service providers to report monthly on every instance of use of a restrictive practice.

17. How is the medical practitioner involved in decisions about the use of chemical restraint?

The service provider must consult the adult's treating doctor, and inform the doctor about the assessment of the adult and the range of strategies proposed to be used in conjunction with chemical restraint. Under the Act, the treating doctor is recognised as a critical stakeholder in the assessment of and planning for an adult where chemical restraint is proposed or in use.

The assessment and positive behaviour support plan required under the Act must show evidence that the treating doctor has been consulted throughout. Only the person's treating doctor can prescribe medication.

18. Does chemical restraint include medication used to treat a mental illness or physical condition?

No. Using medication for the proper treatment of a diagnosed mental illness or physical condition is not chemical restraint. For the purposes of this Act, chemical restraint means the use of medication for the primary purpose of controlling the adult's behaviour in response to the adult's behaviour that causes physical harm or a serious risk of physical harm to the adult or others.

19. Why are there different provisions for chemical restraint (fixed dose) in respite?

Chemical restraint (fixed dose) is medication that is administered at fixed intervals and times. If chemical restraint (fixed dose) in respite is the **only** restrictive practice the adult is subject to, then the Act requires the service provider to obtain consent from a Guardian for restrictive practice (respite) matter if appointed or an informal guardian, and to keep and implement a policy about use of the chemical restraint.

If the adult is subject to other restrictive practices then the service provider will need to obtain consent from the adult's guardian for restrictive practices (respite).

These requirements came about because, during consultation about the draft Bill, representatives of services providing respite to adults with an intellectual or cognitive disability indicated that:

- supporting a person to take regular, fixed-dose medication is an extension of the decision made by the family and their doctor. As such, the respite service provider has little or no involvement in this process other than to support the person to take their medication as prescribed; and
- the full process (risk assessment, respite or community access plan, consent from a guardian for restrictive practice [respite] matter, etc.) may be too resource-intensive for an infrequent service user, resulting in them being unable to offer respite to an adult with challenging behaviours on the basis of service viability.

20. Will there be safeguards to ensure that positive strategies are tried before a restrictive practice is suggested?

The legislation states that the service provider is only compliant with the legislation if they implement the positive strategies outlined in the plan. Monitoring will occur to ensure positive strategies are implemented as required.

21. Whose responsibility is it to undertake the assessment, develop the plan, and seek approval or consent from the relevant decision maker when there are two or more relevant service providers?

Generally, the relevant service provider is responsible for all activities relating to assessment, planning and seeking approval or consent from the relevant decision maker.

Where an adult is receiving disability support from more than one disability service provider, the service providing the most hours of support to the adult should take primary responsibility for coordinating the assessment and planning activities for that adult. For containment or seclusion, this will include Disability Services. For other restrictive practices, this will include identifying someone (usually within the service) to fulfil the role of appropriately qualified or experienced person.

In situations where primary responsibility is difficult to ascertain, or by mutual agreement between service providers, this arrangement may be varied. For clarity, any variation should be confirmed in writing.

Collaboration between service providers for the adult is critical so the single positive behaviour support plan reflects the adult's different needs in different service environments. It is the joint responsibility of all service providers providing disability services to the adult to seek consent from the relevant decision maker, if they are using a restrictive practice.

22. Who must be consulted in the development of the positive behaviour support plan?

During the development of the positive behaviour support plan the adult, their guardian or relevant decision maker and each relevant service provider who is providing disability services to the adult must be consulted and their views considered. Further professionals may need to be consulted if the adult is subject to a forensic order or an involuntary treatment order under the *Mental Health Act 2000*.

When considering the use of restrictive practice services must provide a statement to clients/families that includes the reasons that a service provider is considering the use of a restrictive practice; how they can be involved in planning and decision making; who will make the decision whether or not to authorise the restrictive practice; and what the avenues for complaint, review and redress are.

The statement must be provided to the adult and any interested people in the adult's life. Service providers must also explain the statement in a way that the adult is most likely to understand, giving appropriate regard to the adult's age, culture, disability and communication ability.

Note: under the Act an interested person is defined as “a person with sufficient and continuing interest in the adult”.

23. How are families involved in the decision-making process?

The legislation encourages and supports the important role of family members to remain involved throughout the assessment, planning and decision-making process. Families and significant others must be consulted, and their views considered, at all critical planning and decision points.

Services must also provide a statement to clients/families that includes the reasons that a service provider is considering that a restrictive practice might be necessary; how they can be involved in planning and decision making; who will make the decision whether or not to authorise the restrictive practice; and what the avenues for complaint, review and redress are.

For decisions related to containment and seclusion made by QCAT:

The family member will also be able to participate and put forward their views at the hearing. If unhappy with the decision, the family member can also apply to QCAT for a review of QCAT’s decision.

A provision is also made, under the *Guardianship and Administration Act 2000*, for family (and others) to apply to QCAT to be appointed as a guardian to seek help and make representation for an adult, where a containment or seclusion approval is made. This ensures that families have a voice about the use of those restrictive practices that are authorised by QCAT.

For other restrictive practices

Families are able to make decisions if they are appointed by QCAT as a guardian for restrictive practice matters, or in their capacity as an informal decision maker, depending on the type of restrictive practice proposed. Families will be involved in decision making regardless of whether they are the adult’s informal decision maker or appointed as a guardian.

Assessment and planning

24. Who can undertake an assessment?

Generally for chemical restraint, mechanical restraint or physical restraint, the relevant service provider must ensure that the assessment is conducted by an appropriately qualified or experienced person. The appropriately qualified or experienced person may be a clinician from Department of Communities, Disability Services and Seniors (the Department) but generally the person may already exist within the organisation. For restricting access to objects, the relevant service provider must ensure that the assessment is conducted (an appropriately qualified or experienced person is not required).

For containment or seclusion, the assessment must be conducted by the Department. Clinicians from Disability Services will undertake assessments and develop plans in collaboration with service providers. Disability Services may also assist in other complex cases where a range of other restrictive practices may be in use.

25. What has to be covered in an assessment?

An assessment is required in all situations where an adult is subject to restrictive practices. However, the type of assessment will vary according to the type of restrictive practice and service provided.

When the adult is receiving accommodation support or community support services (or either of these services in combination with respite or community access services) and is subject to containment or seclusion (or a combination of restrictive practices), a *multidisciplinary assessment* is required. When the adult is subject to other restrictive practices, an *assessment* is required.

In either case, the Act sets out the minimum requirements for any assessment of the adult. An assessment must be made by one or more appropriately qualified or experienced persons, and should:

- make findings about the nature, intensity, frequency and duration of the behaviour of the adult that causes harm to the adult or others;
- develop theories about the factors that contribute to the adult's behaviour such as their living environment, low communication skills and /or medical conditions; and
- make recommendations about appropriate strategies for meeting the adult's needs, improving quality of life and the and reducing the intensity, frequency and duration of the adult's behaviour.

If the adult is subject to restrictive practices and is only receiving respite and/or community access services, a risk assessment is required. A risk assessment looks at the risks associated with the provision of respite services or community access services to the adult by the relevant service provider including:

- the risk of the adult's behaviour causing harm.
- the risks of the service environment not meeting the needs of the adult.
- the procedures the relevant service provider will implement to mitigate those risks.

26. What has to be included in a positive behaviour support plan?

A positive behaviour support plan is best practice and is required in all situations where an adult is subject to restrictive practices and is receiving accommodation support or community support services (or either of these services in combination with respite or community access services).

In this case, at a minimum, the positive behaviour support plan must describe the strategies to be used to:

- Meet the adults needs;
- Support the development of skills;

- Maximise opportunities through which the adult can improve their quality of life; and
- Reduce the intensity, frequency and duration of the adult's behavior that causes harm to the adult or others.

The positive behaviour support plan must include at least each of the following:

- A description of the intensity, frequency and duration of the behaviour and its consequences;
- the early warning signs and triggers for the behaviour, if known;
- The positive strategies that must be attempted before using a restrictive practice, including the community access arrangements in place for the adult.
- For each restrictive practice:
 - a demonstration of why the use of the restrictive practice is the least restrictive way of ensuring the safety of the adult or others;
 - the procedure for using the restrictive practice, including observations and monitoring that must happen while the restrictive practice is being used; and
 - any other measures that must happen while the restrictive practice is being used that are necessary to ensure the adults proper care and treatment and safeguards from abuse, neglect or exploitation.
- A description of the anticipated positive and negative effects on the adult of using the restrictive practice.
- The intervals at which use of the restrictive practice will be reviewed by the relevant service provider using the restrictive practice.

There are some additional requirements, depending on the type of restrictive practice proposed. For containment and seclusion, the plan has to assess the suitability of the environment and the maximum amount of time the restrictive practice may be applied. For chemical restraint, details of the medication, how it is to be taken and the name of the prescribing doctor must be included.

27. What has to be included in respite/community access plan?

If the adult is subject to restrictive practices and is only receiving respite or community access services, a respite or community access plan is required.

In this case, minimum requirements for a respite or community access plan are:

- the name of the adult;
- a description of the behaviour that causes harm to the adult or other (the intensity, frequency and duration of behaviour) and consequences (what happened after the behaviour occurred that may have influenced the chances of it occurring again);
- a description of the reasons for using the restrictive practices;
- a description of the restrictive practice being used;
- any strategies that must be attempted before using the restrictive practice;
- procedures for using the restrictive practice, including observation and monitoring measures to ensure the adult's proper treatment and care while the restrictive practice is being used;
- demonstration of why it is the least restrictive way of ensuring the adult's safety; and
- a description of the positive strategies to meet the adult's needs and improve their quality of life (including community access arrangements) and reduce their behaviour that

causes harm.

There are further requirements depending on the type of restrictive practice proposed for example, for containment and seclusion, the plan has to include suitability of the environment and the maximum amount of time your family member can be contained or secluded. Also for chemical restraint details of the medication, how it is to be taken and the name of the prescribing doctor must be included.

Approval and consent

28. What is the difference between approval and consent?

An Approval refers to either:

- An approval given by QCAT for a relevant service provider to contain or seclude, or use another restrictive practice in relation to, an adult with an intellectual or cognitive disability; or
- A short term approval given by the Chief Executive of the Department of Communities, Disability Services and Seniors.

Consent refers to the use of a restrictive practice, other than containment and seclusion, consented to by a guardian for restrictive practice or an informal decision maker.

Consent may be given by a guardian for restrictive practice for containment and seclusion when the adult is receiving community access or respite only.

29. Who can be a guardian?

Guardians are appointed by QCAT and are usually family members or close friends of the adult. Guardians must be over 18 years of age but cannot be a paid carer (a paid carer performs services for the adult's care and receives remuneration other than a carer payment or benefit from the Commonwealth or State Government).

Sometimes there may be nobody available to accept the responsibility, or there may be a dispute about who should act as guardian or concern about the suitability of a proposed guardian. In these situations, QCAT may appoint the Public Guardian to protect the rights and interests of an adult who has impaired decision-making capacity.

30. Who makes the decision about containment or seclusion?

Decisions about containment or seclusion (and these practices in combination with other restrictive practices) will be made by QCAT in consultation with the adult and their guardian or informal decision maker. Where the person is receiving respite and community access services only, the decision is made by a guardian appointed by QCAT for restrictive practice (respite) matters.

Decisions about physical, chemical or mechanical restraint (and these practices in combination with restricting access to objects) will be made by a guardian appointed by QCAT for restrictive practice matters.

If the only restrictive practice is restricting access to objects, consent may be sought from an relevant decision maker for the adult.

For further information, please see the policy and procedures for the full legislative scheme and the information sheets available at www.disability.qld.gov.au , or consult the QCAT website www.QCAT.qld.gov.au

31. Will authorisation to use restrictive practices be long- term or permanent?

No, all restrictive practices will only be authorised with specified time limits and the practice will be monitored and reviewed. The aim of the positive behaviour support plan is to increase positive strategies and reduce or eliminate the use of restrictive practices.

32. How are decisions of the Director- General of the Department of Communities, Disability Services and Seniors reviewed?

Under the Act, there are some decisions that must be made by the Chief Executive of the Department of Communities, Disability Services and Seniors or delegate. These decisions include:

- Not to conduct a multidisciplinary assessment;
- Not to develop a positive behaviour support plan.

Section 187 of the Act provides that an interested person can make an application to the Chief Executive of the Department of Communities, Disability Services and Seniors to review a relevant decision. The application can only be made by an 'interested person' for the decision. This person may be:

- a relevant service provider;
- the adult; or
- a guardian or informal decision maker who was consulted in the decision.

The application seeking a review of a decision must be in the approved form (*Form 6-1 Application for the review of a decision*).

Within 28 days of receiving the application, the Chief Executive of the Department of Communities, Disability Services and Seniors will review the original decision and make a 'review decision' to:

- confirm the original decision;
- amend the original decision; or
- substitute another decision for the original decision.

The interested person will be advised in writing of the review decision, and the reasons for the review decision.

When requested, the Chief Executive of the Department of Communities, Disability Services and Seniors or delegate must also decide on whether to give or not give a short term approval. A person or service provider who is given notice this decision may apply to the Queensland Civil and Administrative Tribunal (QCAT) to review the decision as described in the *QCAT Act 2009* Chapter 2 Part 1 Division 3.

33. How are QCAT decisions reviewed?

Under Section 138 of the *Guardianship and Administration Act 2000*, the Queensland Civil and Administrative Tribunal (QCAT) may give advice or directions for parties who do not agree with QCAT's decision.

If the relevant service provider or an interested person does not agree with a decision made by QCAT, they can appeal the decision to the Supreme Court or apply to QCAT for a review of the decision, if there is a change in circumstances.

If the relevant service provider or an interested person does not agree with a decision made by a relevant decision maker, they can ask for a review of the appointment of the guardian for restrictive practice matters or, if there isn't one, ask for one to be appointed.

Resources to the sector

34. How will the Department assist service providers to comply with the legislation?

The Department of Communities, Disability Services and Seniors has developed policies, procedures and guidelines to assist service providers to meet the requirements under the legislation, and implement best practice in positive behaviour support.

The Centre of Excellence for Clinical Innovation and Behaviour Support will provide information and support service providers to build their capacity to implement positive behaviour support in their organisations and understand the restrictive practices framework. This will include:

Providing guidelines and educative resources such as:

- guidelines and a model plan for positive behaviour support plans;
- guidelines on the types of actions which require approval as a restrictive practice, with a number of scenarios and examples;
- a model statement about restrictive practices (requirement in the Act) to be provided by service providers to people subject to restrictive practices and their support network; and
- specific educative resources about restrictive practices for family members, carers and members of the person's support network.

Delivering training and information sessions:

- to disability service providers in all regions of Queensland to build sector capacity to develop and implement positive behaviour support plans;
- to professionals working in the disability sector on undertaking assessments of people

- with challenging behaviour to increase the capacity of assessors and the quality of assessments, as well as increasing the pool of trained assessors;
- to professionals and service providers about working with people with impaired capacity to assist them to understand their rights;
 - for family members and for guardians for restrictive practice, about roles and responsibilities under the framework, and positive behaviour supports that reduce the need for restrictive practices;
 - to disability services providers about how to comply with the regulation to report on every instance of use of a restrictive practice;
 - Being a central point of contact for advice and support on restrictive practices in general and compliance with the reporting regulation.

Further Information

For more information, refer to the “Positive Behaviour Support” page on the Disability Services website (<http://www.communities.qld.gov.au/disability/key-projects/positive-behaviour-support>) or contact the Centre of Excellence for Clinical Innovation and Behaviour Support on 1800 902 006.

July 2016