Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2024

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Queensland Mental Health Commission submission

Introduction

The Queensland Mental Health Commission (the Commission) welcomes the opportunity to make a submission on the Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2024 (Bill).

The Commission is an independent statutory agency established under the *Queensland Mental Health Commission Act 2013* to drive ongoing reform towards a more integrated, evidence-based, and recovery-orientated mental health, alcohol and other drugs (AOD) and suicide prevention system in Queensland.

One of the Commission's primary functions is to develop a whole-of-government strategic plan to improve the mental health and wellbeing of Queenslanders, particularly people living with mental illness, problematic AOD use, and those affected by suicide. The current strategic plan is *Shifting minds: The Queensland Mental Health, Alcohol and Other Drugs, and Suicide Prevention Strategic Plan 2023-2028* (*Shifting minds*). *Shifting minds* is complemented by two sub-plans:

- *Achieving balance: The Queensland Alcohol and Other Drugs Plan 2022-2017* (*Achieving balance*)
- *Every life: The Queensland Suicide Prevention Plan 2019-2029* (*Every life*).

The Bill has numerous points of connection to strategic priorities under the *Shifting minds*, *Achieving balance* and *Every life* strategic plans. The Commission is currently developing the whole-of-government Trauma Strategy which will focus on the prevention of trauma, improving the supports provided to people who have experienced trauma (and their friends and family), and reducing the long-term impacts on individuals and the community.

During consultations for the Trauma Strategy, the Commission heard overwhelmingly from Queensland communities that strengthening and embedding human rights is essential to developing a trauma-informed framework. The Commission also engaged a number of preeminent academics to prepare Consultation Papers on trauma-informed principles for key stakeholder groups, including the paper prepared on *Trauma and trauma informed approaches for people with disability*.

The Commission welcomes the Bill's focus on the reduction and elimination of the use of restrictive practices in relation to people with disability receiving National Disability Insurance Scheme (NDIS) supports or services or state disability services under the *Disability Services Act 2006*. In particular, the Commission:

- supports an approach which **enhances human rights compliance of service providers** working with people with disability
- suggests that the Bill **strengthens the role of families, carers and support networks** by inserting a requirement in section 159 of the Bill that the senior practitioner consider information provided by and perspectives of families, carers and support networks in deciding an application for restrictive practice
- suggests that the Bill includes **trauma-informed practices** as a 'guiding principle' to underpin the key shifts proposed by the Bill, supported by a trauma-informed framework for decision-making and use of restrictive practice
- notes concern with the **requirement that a senior practitioner consider the terms of a forensic order, treatment support order or treatment authorit**y. Concerns particularly around the varied criteria for such orders/authorities when compared to the criteria for a senior practitioner issuing an authorisation under this Bill

- supports the Pure Clinical Model adopted in the Bill, noting concerns with any **future adoption of the market model**
- recommends that the **complaints process be strengthened** to ensure that meaningful redress is provided, and that the complaints system is trauma-informed and person-centred.

The Commission has a long-standing history of advocating for the removal of restrictive practice, particularly for people with a lived-living experience of mental ill-health. In December 2014, the Commission published the *Options for Reform: Moving towards a more recovery-oriented, least restrictive approach in acute mental health wards including locked wards* report. The Commission is pleased that the directive to lock wards ceased on 1 July 2024 and continues its advocacy for approaches which are person-centred, trauma-informed and prioritise human rights, dignity and the right to self-determination.

Impact of Restrictive Practices for people with disability including psychosocial disability and/or mental ill-health

The Commission strongly advocates for restrictive practices to be reduced as much as possible and only used as a last resort. A key whole-of-government strategic priority in *Shifting minds* is to continue to monitor and reduce involuntary treatment and promote least restrictive practice, including reviewing mental health legislation. This approach is consistent with prioritising the human rights of individuals, particularly persons with disability including psychosocial disability and/or with concurrent disability and mental ill-health.

The incidence of restraint in Australia (23-28%) is considered high compared with the UK, where it is reported that between 7 and 17 per cent of adults with a disability are subjected to restraint.[1]

The use of restrictive practices to manage behaviours that are considered to be challenging results in adverse outcomes for the individual, families and carers (noting carers in the context of this submission refers to unpaid carers, not professional paid carers and/or support worker roles), broader community and the system. People with psychosocial disability and people with concurrent disability and mental ill-health have particular vulnerabilities in respect to restrictive practice. Seclusion and restraint are often experienced as emotionally unsafe, disempowering and retraumatising. Serious adverse psychological consequences can include reduced quality of life and well-being, increased depression and anxiety and increased risk of self-harm. In cases of physical restraint, this can place both the person subject to the restrictive practice and those implementing the practice at serious risk of harm. Restrictive practices have caused serious trauma and even death.[2]

People with disability, when describing their experiences of restrictive practices as disempowering, dehumanising and humiliating, often identify the ways these experiences impact the relationships they have with workers and staff who are authorised to commit these acts of violence and harm.[3] The use of restrictive practices perpetuates mistrust in the system, reinforces hierarchical models of care and impacts the integrity of services and systems by impeding individual empowerment, choice and agency.

Further, the use of restrictive practice can have significant impacts on staff, particularly staff members with lived-living experience including peer workers and recovery support workers. Some staff may be requested or compelled to be involved in the use of restrictive practices which do not align with human rights or their own ethics and perpetuates re-traumatisation, however, remain beholden to their employer due to the power imbalance between employer/employee.

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[1] Emerson, E., Kiernan, C., Alborz, A., Reeves, D., Mason, H., Swarbrick, R., Mason, L., and Hatton, C. (2001). The prevalence of challenging behaviors: A total population study. *Research in Developmental Disabilities*, 22, 77-93.

[2] McVilly, K. (2009). Physical restraint in disability services: Current practices, contemporary concerns, and future directions. *A report commissioned by the Office of the Senior Practitioner*. Melbourne: Department of Human Services; Paterson, B., Bradley, P., Stark, C., Saddler, D., Leadbetter, D., and Allen, D. (2003). Deaths associated with restraint use in health and social care in the UK: The results of a preliminary survey. *Journal of Psychiatric and Mental Health Nursing*, 10, 3-15.

[3] University of Melbourne, University of Technology Sydney and University of Sydney. (2023). *Restrictive Practices: A pathway to elimination.*

The role of families, carers, and support networks

The Commission supports the Bill's position that a service provider must provide supports or services in a way that ensures the person, and their family and unpaid carers are given an opportunity to participate in the development of strategies for the care and support of the person. However, this could be strengthened by inserting a requirement in section 159 of the Bill for the senior practitioner to consider information and perspectives of family and friends when deciding an application to authorise restrictive requirement. A focus on family, carers and support networks is consistent with whole-of-government priorities in *Shifting minds* to strengthen effective and meaningful engagement and participation of people with a lived experience, families and carers in policy, planning, evaluation, service delivery and governance.

It is essential to recognise the role of families, carers and support networks and the impacts of restrictive practices. Family, carers, and support networks play a critical role in supporting and caring for many people with disability. At the same time, many people with disability live independently of informal support structures.

Families, carers, and support networks have articulated the significant impacts of restrictive practices on their loved ones. There have been anecdotal reports that family members who question or oppose use of restrictive practices are deemed a 'problem' by the service adopting such measures, with some prevented from further contact with family members by the service seeking a guardianship order.[4] These practices must be mitigated through safeguards and appropriate intervention where service providers fail to work in partnership with families, carers and support networks.

To meaningfully shift to a person-centred approach which (where appropriate) considers the individual in the context of their support system, the Bill must strengthen the role of families, carers, and support networks.

Inconsistency of restrictive practice and human rights

Use of restrictive practices is at odds with international human rights obligations for the treatment of people with disability. The *Human Rights Act 2019* (Qld) provides that a person must not be subject to torture; treated or punished in a cruel, inhuman or degrading way or subject to medical or scientific experimentation of treatment without the person's full, free and informed consent.

The United Nations' Convention on the Rights of Persons with Disabilities (2006), an internationally accepted convention, states that individuals have a non-derogable guaranteed freedom from torture and from cruel, inhumane or degrading treatment or punishment (Article 15). In addition, governments are required to protect the physical and mental integrity of persons with disabilities, just as for everyone else (Article 17) and enact laws and administrative measures to guarantee freedom from exploitation, violence and abuse (Article 16).

In 2013, the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment stated that:

> *"It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions."*

This was re-enforced by the United Nations Committee on the Rights of Persons with Disabilities:

> *"The Committee has called upon States parties to protect the security and personal integrity of persons with disabilities who are deprived of their liberty, including by eliminating the use of forced treatment, seclusion and various methods of restraint in medical facilities, including physical, chemical and mechanical restraints. The Committee has found that those practices are not consistent with the prohibition of torture and other cruel, inhuman or degrading treatment or punishment of persons with disabilities, pursuant to article 15 of the Convention."*

Further, there are strong human rights obligations relating to prohibition of discrimination against people with disability and rights to protection from violence. In so far as restrictive practices represent a form of violence that is applied on a discriminatory basis to people with disability, then these practices, even where they do not rise to the level of torture and cruel, inhuman or degrading treatment or punishment, are at odds with international law.

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[4] Office of the Senior Practitioner. (2009). Experiences of restrictive practices: A view from people with disabilities and family carers. *A final research report to the Office of the Senior Practitioner (Vic).*

Embedding trauma-informed principles

> *"Minimising, and where possible eliminating, restrictive practices will help to reduce the trauma inflicted on people with disability by health and community services."*
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> (Stakeholder perspective, Trauma Strategy Consultation)

The Commission supports the purpose and intention of the Bill and commends the Queensland Government on shifting to a model of restrictive practice as a last resort for people with disability. However, the Commission:

- suggests that the guiding principles of the Bill be amended to provide that senior practitioners and providers must recognise the impact of trauma and the need to adopt trauma-informed practices
- recommends the development of a guiding framework which includes trauma-informed principles in relation to decisions made under the Bill and the regulated use of restrictive practice pursuant to such decision.

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability reported that over half of Australians with disability have experienced physical or sexual violence[5]. People with disability are more likely to experience multiple incidents of violence and are more likely to know the perpetrator.[6] Due to lack of appropriate support options, people with disability can often experience the impacts of trauma for between 3-20 years after the incident takes place.[7]

The way forward must be trauma-informed in recognition of both the lived-living experiences of restrictive practices and its impacts, and in acknowledgement that people with disability (whether or not subject to restrictive practices) are more likely to experience violence, abuse, neglect and exploitation. This is consistent with Article 16 of the Convention on the Rights of Persons with Disabilities (2006) which provides that:

> *"State parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender and age-specific needs.*

A 2018 evaluation of a program model for minimising restraint and seclusion found that when staff were trained in trauma-informed practices there was a 99 per cent decrease in restraint frequency, a 97 per cent decrease in staff injury from restraint, a 64 per cent decrease in client-induced staff injury, and an increase in client goal achievement of 133 per cent.[8] This demonstrates the effectiveness of trauma-informed practices and frameworks in reducing restrictive practices and enhancing safety for both people with lived-living experience and workforce.

One example of a high-level framework that may inform the recommended development of a guiding framework is the 'Six Core Strategies to Reduce Seclusion and Restraint Use' (Six Core Strategies) developed by the National Association of State Mental Health Program Directors in the USA. The Six Core Strategies proposes a trauma-informed approach to services, summarised as[9]:

- Leadership and organisational change: a vision for restraint reduction, developing performance improvement plans and appropriately establishing oversight and evaluation for every use of restraint

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[5] Royal Commission into Violence A, Neglect and Exploitation of People with Disability (2023). *Final Report: Executive Summary, Our vision for an inclusive Australia and Recommendations*. Canberra: Commonwealth of Australia; 2023.
[6] Royal Commission into Violence A, Neglect and Exploitation of People with Disability (2023). *Final Report: Executive Summary, Our vision for an inclusive Australia and Recommendations*. Canberra: Commonwealth of Australia; 2023.
[7] Houck, E, and Dracobly JD (2023). Trauma-Informed Care for Individuals with Intellectual and Developmental Disabilities:From Disparity to Policies for Effective Action. *Perspect Behav Sci,* 46(1):67-87.
[8] Craig, J and Sanders, K. (2018). Evaluation of a program model for minimising restraint and seclusion. *Advances in Neurodevelopmental Disorders*, 2, 344.
[9] National Association of State Mental Health Program Directors. *Six core strategies for reducing seclusion and restraint use.*
https://www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf

- Use of data to inform practice: collection of data on restrictive practice with continuous monitoring and evaluation against performance improvement plans
- Workforce development: creation of environment whose policies, procedures and practices are based on the principle of recovery and trauma-informed systems of care
- Use of restrictive practice prevention tools: use of tools and assessments for prevention that are integrated into policy and procedures and each individual's personal plan
- Recognition of lived-living experience: full and formal inclusion of people with lived-living experience, children, families and external advocates in various roles and at all levels in the organisation to assist in the reduction of restraint
- Debriefing techniques: recognise the usefulness of analysing every restrictive practice event.

By prioritising a trauma-informed and person-centred approach, Queensland can recognise the historical and ongoing injustice experienced by people with disability and shift to an approach that enhances autonomy, choice and dignity of risk.

Restrictive Practice Authorisations

The Commission strongly advocates for a departure from restrictive practices, however, acknowledges that in some circumstances, restrictive practice may need to be used as a last resort under careful consideration.

The Office of the Public Advocate (Qld) has previously identified the senior practitioner model as a way forward, operating consistently across multiple settings including disability services, residential aged care facilities and health care. The Commission supports this model provided that it is person-centred and re-enforces that restrictive practices should be reduced and used only as a last resort.

It is noted that the proposed provisions of the Bill align with this model, with a senior practitioner permitted to make determinations on authorisations for the use of a regulated practice provided that all criteria are met.

The Commission is, however, concerned with the effect of the following matter for consideration by the senior practitioner when determining whether to grant an authorisation for the use of regulated practice:

> *"(c) if the senior practitioner is aware the person is subject to a forensic order, treatment support order or treatment authority under the Mental Health Act 2016—the terms of the order or the authority."*

The Commission is concerned that blanket application of this provision under section 155(1)(c) may have unintended consequences for persons with a lived-living experience of mental ill-health. In particular:

- There is no requirement to have regard to whether the terms of the order or authority are specific for particular contexts which may not be relevant or applicable to permit a disability service or NDIS provider to exercise restrictive practices. For example, an individual subject to a treatment support order under the *Mental Health Act 2016.*
- The *Mental Health Act 2016* imposes different criteria for issuing such an order or authority than the Bill proposes. The effect of this is that an individual who would not be subject to an authorisation under the Bill in the absence of section 151(1)(c) may nonetheless be subject to such due to an order or authority under the *Mental Health Act 2016*, which is issued on a different basis with different criteria.
- There is no requirement for the senior practitioner to have regard to whether circumstances have changed since the time the order or authority was made (even if such order or authority remains effective).
- It is unclear how the senior practitioner will obtain such information and who bares the onus of providing this information.
- There is no right for a person with disability, or their family, carers or support network, subject to such order or authority to provide additional context or information.

Models for reform

The Commission supports the adoption of the Pure Clinical model implemented by the Bill, noting that other options for reform include:

- Market model which vests some authorisation authority in the market in relation to lower risk restrictive practices. The senior practitioner would have responsibility for all other authorisation decisions.
- Tribunal model which requires expert clinicians in the Office of the Senior Practitioner to authorise all short and long-term applications for the use of restrictive practices.

The Commission strongly urges that any use of the market model be carefully considered and that people with lived-living experience are engaged in any future planning for this model. While the Commission recognises that this may or could be adopted for 'lower risk restrictive practices', there are serious concerns that these practices can still have long-term impacts when it is not used in a way that is trauma-informed and person-centred.

There are significant concerns with market readiness and capacity to implement a person-centred approach in adopting this model, given that the 'market' may have been the very perpetrators of harmful and/or unauthorised restrictive practices. In 2020-21, the NDIS Quality and Safeguards Commission published that over a million uses of 'unauthorised' restrictive practices were reported.[10] It is vital that any model adopted mitigates the real and tangible risk of providers using restrictive practices in a way that is not supportive of 'restrictive practice as a last resort'. Further:

- Restrictive practices are often used by providers and workforce due to low staffing levels and the inability to consistently watch "at-risk" patients due to a large workload;[11]
- Frontline staff working in disability services under the NDIS reflected that workers recognise 'deep inequalities pervading their organisations', with these inequalities recognised by staff to lead to unsafe, abusive, violence and neglectful experiences of people with disability being overlooked or dismissed by staff and management.
- People with disability have identified their experiences of restrictive practices in relation to institutional cultures of control, including cultures where the convenience and priorities of the workplace appear to guide and inform staff use of restrictive practices and cultures of silence and secrecy in relation to the use of restrictive practices.

Without addressing these factors which contribute to the use of restrictive practice, the market is not in a position to make decisions about the use of even 'low risk' restrictive practices in a way which prioritises human dignity, agency and self-determination of people with disability.

The Commission suggests that until there is significant institutional and systemic change, the market approach should not be adopted in Queensland. The capacity-building of the workforce is a strategic whole-of-government priority in *Shifting minds* to facilitate opportunities for the health, education, justice and human services workforce to develop skills, knowledge and competencies to respond to trauma, culture, age and neurodiversity.

Accountability

The Commission recommends that accountability and enforceability for breaches of the Bill are strengthened. Division 5 allows the senior practitioner to maintain a system that deals effectively with complaints; however, this is not prescriptive of *how* this system must operate.

It is the Commission's position that any complaint system must be trauma-informed, person-centred and place the perspectives of people with disability and their support systems at the forefront. The current complaints process

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[10] NDIS Quality and Safeguards Commission, Activity Report 1 July 2020 to 30 June 2021, Activity report, September 2021.
[11] Cortis, N, and Van Toorn, G (2021). Safeguarding in Australia's new disability markets: Frontline workers' perspectives. *Critical Social Policy* 42(2)

provides the senior practitioner with the right to determine how to manage a complaint, without any regard to the views of the party impacted by the unauthorised use of restrictive practice.

Further, the person with disability who is impacted by the use of unauthorised restrictive practice should:

- have access to an independent advocate, with investment required by the Queensland Government to ensure that these is well-resourced and funded for every complaint
- have access to a timely determination, noting that while a complaint is being determined an individual may remain in the very environment where the restrictive practice has taken place—which risks ongoing breaches
- have the right to involve family, carers and support networks in the complaints process via a formal mechanism.

Ultimately, accountability must be responsive to the needs of individuals, transparent and provide meaningful redress for individuals impacted by the unauthorised use of restrictive practice.

The Commission supports the Bill's focus on the reduction and ultimately elimination of the use of restrictive practices in relation to people with disability with an approach which is person-centred, trauma-informed and enhances human rights in practice.

The Commission would welcome any further opportunities for consultation and is able to provide additional expertise in relation to the recommendations made in this submission.

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