TERALBA ASSOCIATION INC
Supporting People

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Restrictive Practices Report for Disability Services (Restrictive Practices) and other Legislation Amendment Bill 2013

By Jack Sharp
Director
Teralba Association Inc.

Note – All attached documentation are excerpts from full reports / documents and they are referred to in the following report as (A#). This is to ensure our own confidentiality policy is adhered to. If you would like any extra information in regards to these reports / documents I can attempt to gain the appropriate permissions.

Introduction

My name is Jack Sharp and I am currently the Director of the Teralba Association. I have been with the association for two years and in my current position for 4 months. My experience in the disability sector has ranged from many different organizations and roles over the past 14 years.

The Teralba Association is a small NGO based in Nambour on the Sunshine Coast in Queensland. We currently support 18 men in two large residential facilities. To the best of our knowledge, we are one of the last organizations to be funded under this model.

There is a very good reason why my main goal for 2014 is to deconstruct the facilities and have the residents move out to smaller more homely accommodation – the current facilities are a prime example of legislation and environment creating unnecessary restrictive practices on the residents through no fault of their own. To give you some examples –

Legislation and Local Council

WPHS – A resident cannot lock themselves in their room for privacy due to fire regulations. Apart from denying a person's right to privacy and dignity the argument can be made that we are restricting a person to an object (lock on the door) that may cause harm (fire).

There has to be a one staff member to six resident ratio, after a previous behavioural episode that resulted in a WorkCover claim (A1). This creates the continual issue of restricting activities for many residents because other residents choose not to do the activity. Conversely some residents may have to participate in an activity when they choose not to.

Local Council – requires our kitchen to be a commercial one due to the fact the residents pay us a fee (board and lodging) to support them to cook in their own home. Technically they could have their own kitchen closed down if an inspector witnesses a resident preparing a meal and

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not following council policy. They also consider our residents "vulnerable people" - no different to children or the elderly (A2) by requiring us to have a Food Safety Management Plan which basically restricts what residents can and cannot do in their own home. Many arguments based on the government's own document (A3) have fallen on deaf ears.

Environment

Restricted Access - Apart from the fact the residents live with people they have no choice over, if there is a behavioural incident occurring – best practice is to get everyone away from the incident (A4). If a resident is having a bad week, then there could be nine residents having to stop what they are doing and get themselves to the safety of their own room multiple times a day.

Food Restrictions - We ensure each resident gets to choose a menu item each week and our auditors commend us for that – but let's face it – 17 other revolving people a day are restricted to somebody else's meal choice.

That is a sample of what life is like living in a large residential and the "natural" restrictive practices the people there face every day. Disability Services are supportive of the deconstruction as long as it doesn't cost above our current block funding arrangement. I completely understand the fiscal implications of 18 men receiving Individualised Packages, because per resident we are averaging $40,000 cheaper than NGOs that operate standard three person accommodation services.

It will certainly be challenging to operate smaller accommodation on our current funding levels; however it is my job to move forward and end the environmental restrictive practices in place because of the "we don't have enough money" excuse.

Official Restrictive Practices

The experiences I have had with the official processes have always been positive. Everybody involved from the Community Visitor, Behavioural Specialists, Disability Services and QCAT have been professional and understanding.

Many say the paper trail is too long and time consuming which realistically can be sometimes, but to put some perspective on that, back in 2011 when a Positive Behaviour Support Plan was required for a Physical Restraint to be implemented, it was soon realised that there was nobody qualified enough in the organization to write such an extensive document. Disability Services provided a specialist to write the report which was thorough and quite well done. To be honest, I doubt today there would be anyone who could even come close to matching it. I discuss training later on in this report.

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To many the idea of going to a courtroom and sitting in front of a judge can be daunting, but I have supported people in this situation and left feeling grateful that so much importance is put on the notion of potentially stripping someone of their rights – even if I have disagreed with the outcome(A5).

The following are the two official Restrictive Practices that I have been involved with Teralba and have access to the information. There have also been others such as a short term approval for seclusion, but I was not involved, so I will not make comment.

Restrictive Practice 1 – Restricted access to objects

Person 1 was diagnosed with Prada Willie(A6). The approved restrictive practice was to have all food and drink locked away in the residential to ensure the persons wellbeing. This created a situation where the other nine residents were also restricted, however it was ruled that as long as the other residents had access to three meals a day the approval went forward(A5).

[redacted]

Restrictive Practice 2 – Physical Restraint

Person 2 has been diagnosed with both Schizophrenia and Anxiety [redacted] (A7), thus removing the initial question of whether his medication was a Restrictive Practice [redacted]. The Physical Restraint was introduced when the person would have an aggressive episode and grab the wrists of support workers, thus causing them to remove his hands from theirs.

Reason for Cessation – There was no documented or informal discussion of this practice being used in the 10 months since I had started with the organization as a house manager. I spoke with the person and staff and decided not to renew the approval (A8).

Opinion

In this last section I will go over some of the frontline experiences I have had over the course of 14 years. I cover a lot of aspects that I believe contribute to the overall picture of Restrictive Practices. My aim is to explain that there are many areas to look at before a practice is put into place.

Training and Expertise is the key.

I believe that the choice of a Restrictive Practice is subjective to the people who apply for it on the persons behalf in the first place. For instance, unless there is an advocate that is strongly opposing the introduction of a chemical restraint for behaviour, it can be matter of doctor shopping until a service provider / carer can find the one that will approve a restrictive

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medication by stating that there is an undiagnosed existing mental condition such as schizophrenia, bi polar or depression (A9).

Also, one can use the duty of care vs. dignity of risk approach, using both policies to justify reasoning. For example "I believe Mr X needs a RP because it is our duty of care to ensure he doesn't hurt himself or anybody else" (A10) or alternatively "I believe Mr X needs a RP so that he can become a valued member of society and experience dignity of risk"

Unfortunately it seems a Restrictive Practice can be placed on an individual purely based on the under trained expertise (or swift tongue) of a support team or carer.

The different standards required for Certificate3 and 4 in Disability can vary significantly depending on the RTO (registered training organisation) delivering the content. Some RTOs can teach a subject such as behavioural support in 6 hours, have the student complete an essay and be marked as competent along with RPL. However the official Tafe Certificate 3 & 4 in Disability requires students to complete a whole unit comprised of 10 weeks to cover the subject. The idea that support workers can RPL a subject as important as behavioural support is baffling to me.

As wonderful as the NDIS will be when it comes into play, judging from the figures that are so prominently rumoured within the sector, there will be a 50% - %100 growth of the industry. My gravest fear will be the massive influx of poorly trained support workers.

The sector is mentally challenging for a lot of people. I fully expect the amount of stress related WorkCover claims to increase out of proportion with the staff increase due to the unexpected complexity of being a good support worker. The amount of unreported restrictive practices and applications for reported cases will undoubtedly increase as time goes on due to undertrained people delivering supports.

However, looking back, the introduction of the Disability Services Act 2006 made a lot of change within the culture of the sector and restrictive practices. It made NGOs question their values, policies and procedures; support staffs look at their role in a different light and undoubtedly freed many people from unwarranted and illegal constraint.

I hope that the Disability Services (Restrictive Practices) and other Legislation Amendment Bill 2013 can look at all aspects when it comes down to improving / changing the processes. I hope that it can re achieve NGOs and support staff to again question their values, policies and procedures. My first point of action would be to look at training in the sector and installing a blanket training program that all service providers and carers must complete before any Restrictive Practice on a person's freedom is introduced.

Secondly I would look at the application process itself. I understand that most times a Restrictive Practice application is a last resort made by people that do not know what else to do, however as I have explained ,there are loopholes and jargon that can be used in the wrong way.

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The challenge will be to make the process simple for those who do actually require assistance, yet complex enough to ensure people are not being constrained through empty reasoning and manipulation of policy.

Thank you for the opportunity to submit this report on the Disability Services (Restrictive Practices) and other Legislation Amendment Bill 2013 and I hope I have raised some interesting talking points.

Good luck.

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Attachments

A1 – Led to 1 to 6 ratio

Good Afternoon Everyone

Today I met with [redacted] Principal Inspector (Ergonomics), and Raymond Regional Operations Manager, from Workplace Health and Safety Queensland, Department of Justice and Attorney-General.

This was a result of the assaults that occured to some of our staff when was not well. Despite all of the measures put in place to alleviate the situation, it has been deemed by the WPH&S Queensland that the [redacted] site does not comply with Section 27A of the WPH&S Act 1995 - Managing Exposure to Risks.

I have been given information by WPH&S and will contact the relevent places to seek help in ensuring that the Mapleton Site becomes compliant with relevant sections of the Act. Teralba has been given until 28 February 2012 to ensure the contravention is remedied.

A2 – Basis of council argument

In relation to vulnerable populations, the Regulation prescribes that the following licensable food businesses must have an accredited food safety program:

2. A relevant facility that processes potentially hazardous food for at least six persons in the facility's care at a time.

   Example:

   A 55 place child care centre provides long day care to pre-school children and provides lunches and morning and afternoon tea to the children. The food is processed in the centre's kitchen and includes potentially hazardous food.

A3 – They don't seem to read the second page

A ***relevant facility*** means any of the following –

a) an aged care facility
b) a facility that provides care, including palliative care, to persons with a terminal illness
c) a day hospital licensed under the *Private Health Facilities Act 1999*, part 6, that provides haemodialysis or cytotoxic infusion health services
d) a centre based service licensed under the *Child Care Act 2002*, part 2, other than a school age care service under that Act
e) an approved education and care service under the Education and Care Services National Law (Queensland), other than—
   i. a family day care service under that Law; or
   ii. an education and care service under that Law providing education and care primarily to children who attend school in the preparatory year or a higher year

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A4 – No plan equals confinement

IF A CLIENT EXHIBITS CHALLENGING BEHAVIOUR

If a client exhibits challenging behaviour and is in danger of harming himself or others or persistently destroys property, the following steps are to be taken:

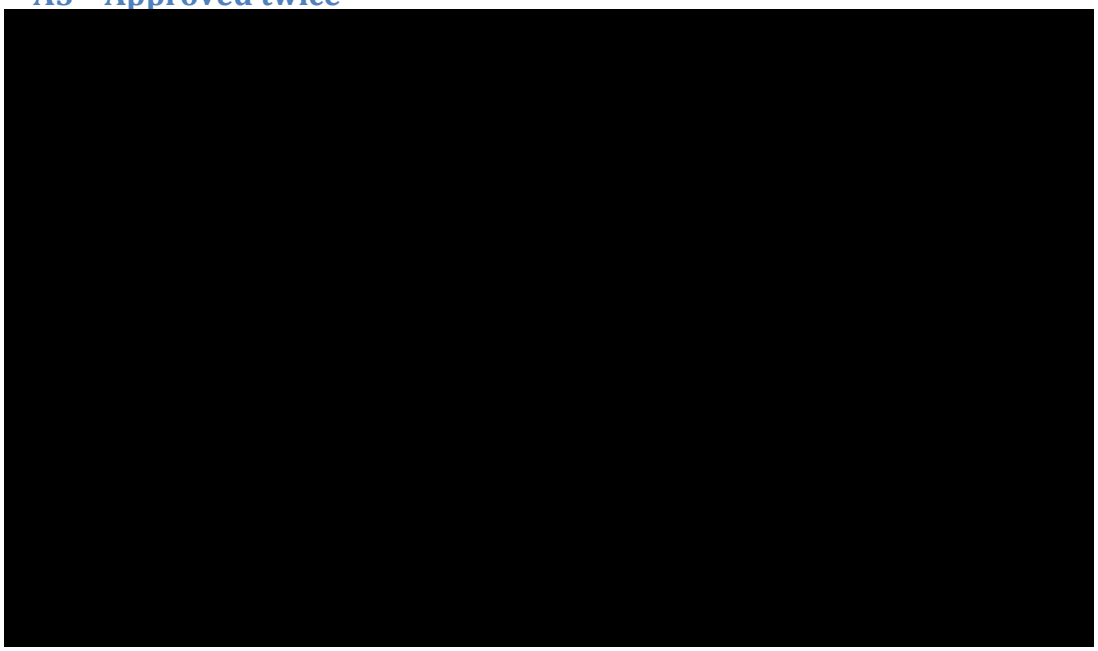
If a behaviour management plan exists for this behaviour:

1. Ensure other clients are safe and are removed from the area.
2. Try to calm the client through positive, redirective strategies contained in the client's behaviour management plan.
3. Implement the behaviour management strategies of the behaviour management plan and CONTACT RSM/QCCC or NOMINATED AFTER-HOURS PERSON as appropriate.

If no plan exists for this behaviour and the client is a danger to himself or others:

1. Ensure other clients are safe and remove from the area.
2. CONTACT THE QCCC/ADMINISTRATOR or NOMINATED AFTER-HOURS PERSON.
3. Attempt confinement, if safe to do so.
4. Contact the client's GENERAL PRACTITIONER or CONTACT THE POLICE if appropriate.
5. Treat any injuries.
6. RECORD ALL INFORMATION in the client's individual file, the communication book, and complete incident report form.
7. QCCC/ADMINISTRATOR to organise debriefing, if required.

A5 – Approved twice



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A6 – Diagnoses description

Summary

Prader-Willi syndrome is a rare genetic disorder that affects development and growth. Characteristics may include short stature, skeletal abnormalities, eye problems, intellectual disability and excessive eating, which often leads to obesity. There is no cure, but treatments can improve the child's quality of life.

A7 – From a Positive Behaviour Support Plan

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A8 - Cessation of Practice letter

Date – 3/8/2013

Office of Adult Guardian
PO Box 13554
George St
Brisbane QLD 4003

RE – **Restrictive Practice**

To Whom It May Concern

This letter is to confirm that Mr is no longer under any restrictive practice. Outlined below are the reasons for not renewing the Positive Behaviour Support Plan.

Physical Restraint

1. There has been no recorded or informal notification from any staff member within the last 10 months that they have had to use this practice.
2. The entire staff team has had specialized training with & peers from the Disability Services IBS Team, concentrating on Behaviour Management and Active Support. The training has been an invaluable tool for the Mapleton site, leading staff to a better understanding and management of situations that they may have reacted differently to in the past.
3. Most importantly, whilst still has verbal outbursts - these are more manageable and becoming less in duration and frequency.
4. I currently have completed the Quarterly staff supervisions where I informed each member of staff of this change - no one had an issue.

A9 – All relating to one person, different doctors.

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A10 – Actual note posted in staff room before my time

PLEASE NOTE