



Quality Lifestyle Support

Enhancing the Lives of Individuals

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To: hpsc@parliament.qld.gov.au 9th January 2014

RE: Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2013

Legislation to prevent harm and abuse to some of the most vulnerable people in our society is crucial to the preservation of reversion to institutional models. However, in applying such legislation, governments must also be mindful of the potential to harm within processes aimed at protecting.

Quality Lifestyle Support, as an entity, has supported and promoted the use of the relevant legislative coverage to meet the community living needs of individuals whom the organisation supports. In this submission, we would hope to put forward practical and less intrusive measures that will have the same, if not better, results for those supported. Government and service providers along with the professionals are empowered to develop responses to behaviours that are at times harmful or potentially harmful to supported individuals and members of the community.

The below are a list of quotes and responses from senior staff who are at the coal face dealing with the adoption and implementation of restrictive support measures.

Mandated guidelines in relation to restrictive practices are essential to avoid the abuse of restraints, however consistency needs to be addressed, as many of the issues revolve around the misunderstanding and impracticality of the practices. Further, the current legislation does not account for the individual, but rather a one size fits all approach, that is unworkable in reality and creates additional workloads for people within the sector and each agency. In many instances, to negotiate around the legislation, effectively costs the client and the organisation money and time and therefore frustration to produce an outcome which is logical and in the best interests of the client. Fair and reasonable is not mentioned in the bill at all, yet whilst open to interpretation, is critical in reducing the bureaucracy involved as well as costs to organisations and the individuals involved. The interpretation of fair and reasonable could be explained within the legislation.

Further to this, where an individual co-tenants with others, a restrictive practice for one, essentially means a restrictive practice for all within the house. EG: There are many clients who have difficulties restricting their food intake and will eat whatever is available, regardless of what it is. A logical and effective response to this is to either limit the amount of food available within the house or to lock food away, so that food intake can be monitored and controlled to healthy portions. Buying less food, means more frequent trips to purchase more food and people with the impact of a disability in their lives are frequently unable to afford constant trips to the shops and will try to buy in bulk as every cent is needed just to survive. Locking it away, essentially means that it is locked away from all, even though they can request it at any time. Both options create either a "win-lose" or a "lose-lose" situation for each tenant. Add to this the Community Visitor Program who then question whatever option has been put into place, thereby creating additional work and the use of time that is often unallocated in relation budgets, in order to clarify and negotiate issues that really should not be considered issues.



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The use of chemical restraint also creates many difficulties. Government always speaks of community involvement, yet the use of any medication that assists the individual in staying in the community often creates an environment where participating within the community is unachievable due to negative behaviours, as these behaviours can frequently put the public at risk.

It also appears that doctors are being second guessed in the treatment of their patients and that they are not aware of the individuals needs in relation to their health. However it is not the doctors who are questioned, but organisational staff who do not have the qualifications to answer questions in relation to the use and requirement of prescribed medication. I personally have a degree and over a decade of experience in human services, and I do not feel comfortable questioning the qualified and considered solutions made by qualified medical practitioners in relation to medication. This is not my role, nor should it be. I need to be able to work on the presumption that medical practitioners know what they are doing and understand the consequences of any actions taken. I also need to presume that the doctor has the best interests of the client in mind, given all of the information they receive, so that the individual can remain in the community and that the public are safe.

There are also Workplace Health and Safety issues in relation to chemical restraint. Should a doctor or other qualified medical practitioner not prescribe medication due to it being a behavioural modification medication, support workers and other agency staff, as well as the public are put at risk. Support staff are hard to employ at the best of times, and if a client is prone to abusing others physically, then the workers themselves are more likely to either remove themselves from the sector, which the sector cannot afford, understandably refuse to work with the individual, which then leave the individual unsupported, or they apply for a worker's compensation claim. Frequently, medication is given as a PRN after an incident has occurred. It is too late then, the horse has already bolted.

It is essential that qualified medical practitioners are assumed to have the knowledge and the best interests of the client in mind in the prescription of behavioural modification medications for fear of individuals not being able to access the community due to public safety, individuals themselves not receiving medication they need, and the fear that they will be removed from society and institutionalised.

All forms of restrictive practices also put additional strains on the police service as they are the ones who are most likely to be called where there is an escalation. They too are constrained by the current legislation which restricts their ability to perform their roles. Many instances have occurred whereby the police themselves seem powerless, and options they can offer are logical and effective, but frequently are not allowed under the current legislation and more often than not they are reluctant to arrest and place a person with the impact of a disability in their lives into custody, as the comprehension of what custody is, does not register with the client and is therefore effectively useless and would do nothing but clog that custodial system which is already under strain.

The process that is currently in place to request the use of restrictive practices is cumbersome and repetitive and extremely time-consuming. The reports that are required to be prepared are onerous and essentially take more time and funding to write than the funding provided to work with that client at a coordination level. This in essence means that all organisations need to donate time and money in order to request restrictive practices, which means that not only does this have an



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impact on that individuals service delivery, but also other clients, as there is only a limited amount of time in a day/week. Something, somewhere needs to not occur for someone. Services provided to all clients within each organisation are therefore stretched simply because of bureaucracy.

This is not to say that there should be no accountable system in place to ensure that restrictive practices are only used where required and not abused, far from it, but it does mean that a system is required that is supportive of individuals, the agencies working with the client or any trust in the medical fraternity. Instead, it is almost an argument on why the use of restrictive practices should be utilised. The system should not be prescriptive and onerous, but reflect what is required and then worked in such a way that minimises, rather than maximises red tape and time requirements.

My professional opinion is that rather than a complete upheaval of the system, adjustments to interpretation of what constitutes a restrictive practice and when, and training across all parts of the sector to clarify these issues may not only provide better outcomes, but would also reduce the costs of such changes significantly. Any changes made should reflect logic and practicality, rather than simply being prescribed. Evidence based feedback and practices are always a good place to start. At the end of the day, it is about the supported individual and what will work best for them so that they can have the greatest life they can. This is the base on which to build the legislation.

PC

The main issue I have had with RP is the community visitor questioning myself and my staff re medication and its purposes. Although I look at information and I have some idea what the medications purposes are I'm not a doctor and I can't make that call.

TT

I have concerns with restricted access to objects as currently putting half a bag of tomatoes away is restrictive even if the person has access to the first half and having the second half presented when the first lot runs out, however buying a smaller portions isn't considered a restrictive practice.

Locking doors is currently considered a restrictive practice, despite almost all of the population locking their doors at night for security reasons. As long as people are able to leave freely of their own choosing, it cannot be deemed as a restrictive practice. I personally lock my doors day and night.

As far as the definitions they are loose and subject to interpretation even amongst sitting tribunal members. As such, you can get a different result on definition of chemical restraint depending on who is sitting on the day. I have seen this with one client in particular where the definition has created an unstable and inconsistent outcome for the individual.

The PBSP plans are long and repetitive and do little to recognise the actual person involved as a person. Non-restrictive plans seem to be more about strategies and recognising the person, their valued role and their strengths and how to build on these, whereas restrictive practices plans seem more focused on meeting all the requirements of legislation and have very little to do with the individual.



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I have also discussed Restrictive Practice (Chemical Restraint) with some of our client's GP. He was formerly a rural practicing doctor who has 30 years of experience in treating patients with and without disabilities.

In his view, the suggestion of a move to have all drugs falling under the definition of chemical restraint only to be prescribed by a psychiatrist is discriminatory to rural persons because unless the person with a disability resides in a major centre of population, they are unlikely to have access to a psychiatrist. Also there isn't enough registered psychiatrists and the director of QCIDD would be excluded from prescribing drugs for the purpose of chemical restraint.

ER

Similar issues appear to exist within other organisations and the sector, given discussions via networking meetings etc.

The recurrent themes appear as such:

1. The expectation that service staff have a working understanding of medication.
2. Varying definitions of what is restrictive and what is average. e.g. Locking of doors.
3. Perceptions of assistance v restrictive practice. e.g. The removal of a supported persons hand from a support person's body when grabbed.
4. Lack of knowledge by Police as to the role of support persons and their inability to restrict a person or restrain a person without an endorsed plan.
5. Community Visitors questioning staff regarding decisions made by tribunals, doctors or guardians.
6. The onerous workload created within the plans that carries nil, or little compensation to the support agency.
7. Professionals e.g. doctors having to be held accountable and questioned by support agencies when prescribing particular medications.
8. Access to specialists e.g. psychiatrists for review and treatment.

Each of the above are not insurmountable issues and do not necessarily require legislative change, but do require addressing through a number of other practical means as outlined below.



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1. ***The expectation that Service staff have a working understanding of medication.***

Currently, there is a perception by some visiting authorities and sitting tribunal members that funded services have within their capacity the ability to train, and ensure understanding of medication applications, the reasons for prescribing, the side effects, review processes and the like. The reality is that the average support worker/carer isn't, and will never be, equipped educationally to meet this demand.

Section 32

Insertion of new s 123ZZDA

After section 123ZZD—

insert— 123ZZDA Requirement to keep and implement procedure

(1) This section applies to a relevant service provider who uses a restrictive practice in relation to an adult with an intellectual or cognitive disability.

(2) The relevant service provider must keep and implement procedures that ensure an individual acting for the relevant service provider who uses the restrictive practice in relation to the adult—

*(a) has sufficient knowledge of the requirements for lawful use of the restrictive practice;
and*

(b) has the skills and knowledge required to use the restrictive practice appropriately

If legislation dictated this as a requirement, this organisation along with most, would cease to function and supported individuals would require hospitalisation or institutionalisation. The processes therefore need to be reflective of this. (a) and (b) above are subjective and do not cover education or qualification levels. Support workers are in general very adept at following clear concise instructions within plans created by professionals. It is the responsibility of professionals to ensure compliance via sustainable resourced processes (including resourced education, specifically for the individual requiring a restrictive practice). This simply means that medical issues are the purview of a qualified medical practitioner. Therefore, the reasoning for treatment and the plan for that treatment falls within their domain, however the monitoring of such is well able to be carried out within the funded service. Here again though, the analysis of treatment/outcome can only be given as evidence by the service provider to the treating professionals, opinions yes but, definitive answers must come from the treating professionals. Within reviews, it is the treating professional who should be responsible as in common law, anything applied carries their authorisation or prescription. Obviously the service is responsible if any variation occurs in relation to a treatment plans' application if the variation is carried out by the service provider. It should be remembered that staff employed by the majority of support agencies do not prescribe medication, medical professionals do. Services do not dispense medication, this is the domain of a Pharmacist, Doctor, Paramedic or a Registered Nurse. All that support providers should be responsible for, is assisting a supported individual to take medication at a designated prescribed time in line with a prescribed plan. This has clearly been addressed in coronial inquests in the past with clear determinations on the responsibilities addressed.

Recommendation;

Clear instruction to all involved parties from the Chief Executive of the relative purview and responsibility of the parties, including who will inform relative parties and carry out planning and reviews. The below recommendation in 7 would also address this area. “*see below”



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2. Varying definitions of what is restrictive and what is average. eg. Locking of doors.

Above in responses from senior staff it can be noted that the interpretation of the legislation is often questioned, this comes from the subjectiveness of some sections and the lack of consistent training available to sector staff with regard to particular areas. Locked doors and windows is a primary area as is the laying on of hands in a guiding manner as opposed to a restrictive manner. Common sense should prevail but, as has been found with younger workers coming into the sector who were not working during initial implementation, their interpretation given later training is somewhat different to the longer term beliefs. Again one single point of contact, to resolve these areas of contention is required; not QCAT, Adult Guardians or departmental workers. Medical professionals or NGO advisors. Clarity from a single point of reference, with an appeals process for contentious issues.

3. Perceptions of assistance v restrictive practice. eg. removal of a supported persons hand from a support person's body when grabbed.

There are always questions in relation to what a restrictive practice means as compared to assistance to protect the supported person and a community member. Some examples of this, which there are many, are:

- Stopping a supported individual from inappropriately grabbing someone before it occurs, with the use of a hand;
- Stopping a supported person from eating their faeces prior to starting;
- Holding a supported person who is about to hit a window or another person;
- Stopping a supported person from walking onto a road with approaching vehicles or walking into a restrictive dangerous area like a building site or utilities work site.

These examples are commonplace within the sector, however it could be interpreted that all are restrictive practices and at the same time, none would be considered from a "Duty of Care" perspective under Common Law. It is these interpretations that cause a great deal of stress for the supported individuals, family members and the supporting staff, and given that the interpretation is an individual interpretation, inconsistencies will continue to prevail and add to the workloads of support agencies, departmental workers, QCAT, medical practitioners etc. This legislation is supposed to be designed to remove interpretation wherever possible and in doing so, reduce the workloads of all stakeholders, however this is currently not the case.

There is a definite need for clarity in this area, and as part of the definitions, a 'What a restrictive practice is not' would be extremely helpful. Also, an added section within the Act stating requirements where the use of unauthorised restrictive practices are acceptable in certain instances. I for one, would like to see a person stop my loved one from eating their own faeces, rather than being afraid of the ramifications of breaching restrictive practices.

This also raises a question, as to what are the penalties for breaches to each restrictive practice? Is there a definition within the Criminal Code with specific reference to the breaches, as people with the impact of a disability could be considered as vulnerable as children? These questions leave, support workers/carers, organisation staff, guardians and even volunteers anxious and often stressed when working with an individual where restrictive practices are in place or are required.



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4. Lack of knowledge by Police as to the role of support persons and their inability to restrict a person or restrain a person without an endorsed plan.

This would appear to be the easiest issue to resolve as it only requires instruction and education to members of the police service. Recently, Quality Lifestyle Support (QLS) staff have been confronted by a Police Officer stating that we should restrain a client. The same officer questioned the reasoning for a “profoundly disabled person living in the community” This in fact showed the knowledge base of the Police Officer as the person described had Cerebral Palsy in a moderate form. Communication, or lack of ability to communicate effectively, was what appeared to be the determining factor for the Police Officer in this case. In fact, the supported individual has capacity especially in terms of wrong and right and should have been placed under arrest as would any other person who was violent and disruptive in the community. Some police appear to want the right to decide what is right and wrong based on their experience with people impacted by disability. In fact, this is discrimination in another form as very capable people are judged as being childlike and beyond reproach, by the very people who are entrusted to protect the community. We have even heard from current serving officers that the approach taken is the “Their either Mad or Bad”, this being their determining analogy for either arresting or not.

Recommendations:

The clear recommendations for this area is compulsory education re legislation that governs people supported in the community with the impact of disability in their lives. Of course, the restrictive practices legislation is only part of this, but all police need to know that without an endorsed plan, then no level of restraint can be applied by a support worker/carer. It would be pertinent for this education to be developed in consultation with the sector.

7. Professionals e.g. Doctors having to be held accountable and questioned by Support agencies when prescribing particular medications.

It is always hoped that within the sector, agencies and organisations work in the best interests of their clients. However, if this was true all the time then there would be little need for the governance of the legislation. Therefore, safeguards must be in place. However, with the current processes for restrictive practices, especially chemical restraint, much is left to the interaction that occurs when often a minimally skilled worker presents a supported individual to a General Practitioner in a 10 min consultation and says “they are behaving badly they need something to calm them down” or “they are masturbating and its rude and we want something to stop them”. I personally have heard these same types of comments many, many times over my career spanning 30-years. The issue is who is going to benefit by actions taken. It is all too easy for a doctor to prescribe medication and have the client and their support person out of their surgery.

On the occasions when a knowledgeable person attends with a client, they are expected to quiz the doctor on all aspects of their reasoning behind prescribing of a medication and inform, “Well if this is restrictive we have to have a plan and gain authority” etc. Then we have a situation behind closed doors where a doctor is required to make decisions based upon how much work load is required, for the benefit to occur. Do they prescribe and put a reason or diagnosis that indicates that it is not being used as chemical restraint, or do they just not prescribe where necessary for the fear of ramifications later. These are real scenarios that, as an organisation, we have experienced.



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To the point that some GP's will not take on patients with a disability due to the extra workload for no additional reward or acknowledgement of their qualifications or skills, I have personally had a doctor question me as to the medical qualifications held by those making decisions about a person they consider to be their patient. All that can be offered is an assurance that the process is deemed to be in the best interest of the client/patient.

The other less common scenario that still presents from time to time is that of GP's from offshore who have minimal understanding of legislation and also come from countries where institutional support or custodial situations still exist. Their ideology and belief systems are often counterproductive to the development of sound support plans. In these situations a single review point by a doctor with the required understanding of legislation, policy and ideology must be in place.

Recommendations:

The process currently where chemical restraint may be deemed necessary, has many problems given the above.

There are clearly 5 stakeholder groups vying for position and levels of control, being:

1. Doctors who are having their professional judgement questioned or are heavily impacted upon, due to the additional work required to meet obligations.
2. Clients, who are often left out of the equation and just advised.
3. Guardians who are only seen as consent givers after a short briefing having the abridged version of reason given.
4. The relevant government officials, funding programs, QCAT tribunals, Community Visitors who all have a vested interest given their jobs are directly linked.
5. Service providers, who again have highly vested fiscal interests and for some the easier the situation the better.

The process is and has become overtly invasive and harmful in itself. What is meant to safeguard is now so onerous and intrusive, that for some of the above, is just not worth the trouble. The question needs to be asked on how much is now not declared? In doing so, I am sure that reasons given will be similar to those presented. The current cost to taxpayers is also very high and in terms of a productive process, this would be one of the most ineffective non cost-effective processes I have been a party to in 30 odd years of service delivery.

Recommendations:

* This is simple, "scrap the current process".

Install a single overseeing referral point, such as an entity like QCIDD for review of all situations where drugs are endorsed by a local GP, that have the potential as chemical restraint, a mood stabiliser, or sexual drive inhibitor. QCIDD or similar type of entity to be adequately resourced from savings made in the reduction of other overseeing program areas. This entity to be given the



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powers to gain required service information to determine that requirements are in the best interest of the client. For this entity to assist service providers in a similar manner, to the current Behavioural Support Team from the Department of Communities by having qualified personnel to assist and recommend, not dictate as in some current situations. For the entity to create plans that are stakeholder based, with mediums that create a welcoming and appreciative approach to the gathering of information not the draconian, dictatorial approach that prevails today. Those who will oppose this approach are only those who have something to lose via a vested interest in the current system. I believe that this is in line with the current government's viewpoint on outsourcing.

Legislatively the final plans will still require approval via the tribunal, however I would envisage a much smoother process, a much more professional approach, and the taking out of levels of vested interest, thus better empowering clients, their guardians and families in a less intrusive manner.

5. Community Visitors questioning staff re decisions made by tribunals, Doctors or Guardians.

This is an area where an overseeing authority continues to request information from areas that exhibit or influence little or no control. It shows a lack of understanding of role and a lack of understanding of their reason for their work. This organisation has routinely rejected the manner in which the Community Visitor Program operates. Many complaints have been lodged and, on numerous occasions, Community Visitors (CV) have acted well outside of their purview in what I would suggest is exactly what Justice Carter did not want when he made his recommendation that a CV program similar to that operating in Child Safety, be adopted. This program has directly impacted upon very vulnerable people negatively, with regard to restrictive practices. CVs have little to no knowledge of the plans and the requirements of such plans, they try to input which is outside their purview. They do not follow and do not attend training re restrictive practices specifically to the people they visit, thus often transgressing the plans by their questioning, actions and timing. A totally unworkable situation that requires immediate action from government to prevent the ongoing harm and abuse of power, or should I say, perceived power. Their questions require answers from those making determinations on the requirements of a practice. EG a doctor who prescribes, a psychiatrist who recommends etc. No matter what the Community Visitor's qualifications (minimal mandatory), no input should be forthcoming. Theirs is an information and monitoring role with a referral point when issues arise.

Section 31

Section 31 in accordance with the Bill is open to interpretation and is unclear in its intent. It could be interpreted that the use of a restrictive practice could be utilised without going through the designated process, by simply submitting a letter stating the reasons why the service provider is intending on using the practice. Also, there are many adults who do not have the capacity to read or even understand the reasoning or the use of a restrictive practice, and therefore, regardless of how it is written, they will not have the capacity to understand. There are also numerous clients within the sector, where their involvement in the entire process would be extremely stressful and potentially create an environment whereby they display behaviours that reflect the internal anxiety that they do not have the capacity to fully comprehend.

The input of the individual, whilst important, could also lead to challenges later on, when the restrictive practices may need to be utilised. The individual may be willing for the use of restrictive



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practices to occur when necessary at the time that the plan is being developed, however this may change when the realities of the situation start. This may therefore create a situation where the potential for harm to themselves or others may occur, and reasoning will not assist at that time and may cause greater stress to the individual and family members. Clarification around this in the legislation needs to be addressed.

The use of facts sheets for all relevant stakeholders in relation to the specific restrictive practice and the use of, timing and reasoning would definitely be of advantage, as they would explain the situation, processes, review processes etc.

Section 32 Part C

One of the cornerstones of working with people with the impact of a disability in their lives is that the aim is for each individual to lead as normal as life as possible, however this section, in part, reintroduces an institutional requirement. We do not want offices in a person's home. Just this simple thing creates difficulties for individuals and support agencies. What is to occur if the individual does not have room for an office or even storage of organisational documentation? Should they move to accommodate this, most likely creating a greater living expense? Would it not be considered a restrictive practice to have an office full of confidential information and not allow others into it, in their own homes? What if they live with others? Are they not entitled to access all parts of their home as well? It would appear this has not been considered in the drafting of the Bill and goes against years of advocacy and struggle by many to gain the same rights as all citizens.

There are more efficient digital methods that can be utilised that do not have the impact of affecting a person's lifestyle choice, that can assist and often enhance confidentiality and security of information and provide the same necessary mechanisms to assist both individuals and care providers.

In Summary:

Quality Lifestyle Support follows philosophy based upon equality, shared responsibility and enhancement of lifestyle. As an entity we have and will continue to work with the community and its representatives (incumbent governments) to gain the best possible outcomes for those with the impact of disability in their lives. It is for those we exist. In saying this, it is for those that legislation is required to protect and enhance. It should therefore never be a mechanism that harms, hinders or becomes onerous in the lives of people who have the same rights as all other citizens. The moment that legislation crosses this line, it becomes so much easier for increases in assaults upon individual rights. History is full of these stories. Legislators need to be mindful of history when debating the current bill and when reviewing.

In relation to the above issues and proposals we would hope we can assist in this debate and hopefully add to legislation that empowers and enhances the lives of those we choose to support.



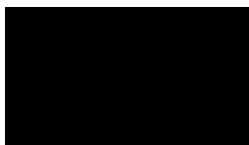
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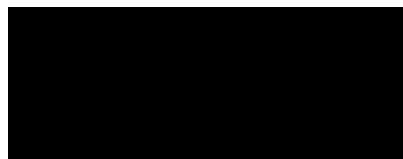
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