Queensland Advocacy Incorporated

Systems and Legal Advocacy for vulnerable people with Disability

Health and Community Services Committee
Parliament House,
George Street,
BRISBANE. Q. 4000

Thursday 9 January 2014

Dear Madam/Sir,

Re: proposed amendments to the *Disability Services Act 2006* and Guardianship and Administration Act 2000

Please find below our submission on the Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2013.

We appreciate the opportunity to contribute to the consultation process.

Yours sincerely,

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Executive Summary of Recommendations

1. **Remove immunity provisions**: QAI is opposed to the extended immunity created by clauses 17, 22 &24. The common law doctrine of necessity & duty of care in addition to Workplace Health and Safety legislation are accessible avenues for those dire and emergency instances should they be required. The need for extended immunity in light of these factors is redundant. These Clauses should be removed from the Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2013 (**The Bill**) as the basis for their inclusion is for administrative reasons such as timeliness of decision making rather than on necessity.

2. **Timing of statement about use of restrictive practices**: (Clause 31) The statement is a crucial safeguard - in the case of the Clause 17, 22 & 24 applications for the use of restrictive practices as proposed the statement is likely to be the *only* safeguard - and therefore must be provided to the interested person and to the adult *at the same time as lodgement of the application to use the restrictive practices.*

3. **The definition of chemical restraint** as proposed in Clause 9 is unclear. It should be reassessed and made more specific. The phrase "using medication [..to] enable a single instance of health care" could be interpreted widely, resulting in unnecessary and or illegal chemical restraint.

4. **Reporting, monitoring and quality analysis of plans and practices** is essential to reducing Restrictive Practices. The Clause 36 provisions should be specific in mandating that plans and practices are reported and assessed for quality against best practice benchmarks. De-identified information should then be made public. Data collection and reporting provides opportunities for the Centre of Excellence for Behaviour Support to monitor plans and practice with a mandate to provide ongoing training and assistance to service providers. Those service providers who consistently fail to reduce the use of restrictive practices must be required to undertake such training and provide evidence of improved outcomes. Should the desired reduction in the use of restrictive practices not be forthcoming this should prompt a review of the service provider.

5. **Free legal representation.** Every person subject to restrictive practices should have access to free legal representation. Many uses of restrictive practices are almost criminal or tortious wrongs such as assault or false imprisonment, and are often experienced as such despite legislative authorisation. QAI proposes that the amendments include a provision similar to ss 426 (3) & (4) of the *Mental Health Act 2000* (Qld) ('MHA') that mandate representation in Tribunal proceedings, and that an adult's lawyer may visit them at any time.[1]

[1] MHA – s 426 (3) If the court makes a confidentiality order for a person, the court must—(a) disclose the information or matters to the person's lawyer or agent; and(b) give written reasons for the order to the lawyer or agent. (4) If the person is not represented at the hearing of the proceeding by a lawyer or agent, the court must ensure alawyer or agent is appointed for subsection (3).
S 347 (2) A legal or other adviser for an involuntary patient in an authorised mental health service may, at any reasonable time of the day or night, visit the patient.

6. **Effective plan implementation.** We urge the Committee to include an additional amendment that guarantees oversight that ensures plans are not just created but actually put into effect. [2] Simplifying plans is a start; as is strengthening the Community Visitor Program, in-service training[3] of support staff and guardians, and plan monitoring.

7. **Decision Makers.** Justice Carter recommended that all decision for the use of restrictive practices be made the by Tribunal (referring to the Guardian and Administration Tribunal – now Queensland Civil and Administrative Tribunal (QCAT). QAI asks that the Committee agrees that the Decision Maker regarding the approval of all use of Restrictive Practices be QCAT.

   Given the concerns regarding the overburden of the Office of the Adult Guardian, capacity of individual guardians to make wise and informed decisions, and the propensity for the Chief Executive to be held to ransom by some service providers, we believe that QCAT is the most appropriate, the most independent and most effective venue for making such decisions about such a serious and important matter in the most timely fashion. This recommendation goes in hand with our position that once decisions are independent and timely there is no need to extend or approve proposed immunity amendments.

8. **Prior use of a restrictive practice does not justify continued use** by a new service provider. Clause 47 would allow a service provider not currently providing disability services to a person to be approved to use seclusion and containment. Any perceived instance of challenging behaviour is not innate to a person or who they are; it is the manifestation of a communication by a person in response to events, issues and or surroundings. Given the circumstantial nature of challenging behaviour, no new service provider or decision maker should act on a presumption that prior restrictive practices are appropriate in a new environment with new support staff.

9. **Duration of Short Term Approval Orders.**

   Short Term Approvals are for emergency and interim provisions for “exceptional circumstances” described as when there is a new service provider or a person moves location.

   In 2010 amendments to the term of orders were made in order to allow time for service providers “to conduct assessments for the adult, develop a positive behaviour

[2] Endeavour Foundation clinician Mr Colin Naylor at the Public Hearing before the Health and Community Services Committee repeatedly emphasized that “ It is not actually about the revision of the plan; it is about making sure that the original plan that has been drafted—the strategies, recommendations and changes to the environment et cetera—has been implemented so the behaviours that you are talking about start to decrease. It is not really about the revision period. [..] it is about making sure that the strategies [..] are being implemented at the coalface. (transcript p 4-5)

[3] Singh, N., Lancioni, G., Winton, A., Singh, A., Adkins, A. and Singh, J. (2009) “Mindful Staff Can Reduce the Use of Physical Restraint When Providing Care to Individuals with Intellectual Disabilities” *Journal of Applied Research in Intellectual Disabilities,* 22: 194-202- These researchers explored how and why alternative approaches to behaviour management could decrease the use of physical restraints. Their study indicates that mindfulness training could decrease the use of restraints in service. This decrease may be related to the ways that staff interact with people with an intellectual disability after training. Specifically, the study suggested that staff who underwent mindfulness training were less likely to have interactions with consumers that prompted aggressive outbursts, and as a result, the need to use restrictive interventions was decreased.

support plan and obtain consent/approval from the relevant decision-maker under the full-scheme requirements".(see the explanatory memorandum to the Criminal History Screening Legislation Amendment Bill 2010 cl 214, which amended s 80ZH.) *"The actual period for the short-term approval will be made by the relevant decision-maker on a case by case basis. All other conditions for a short-term approval, which are aimed at safeguarding the individual, will remain."*[4]

Given that the proposed amendments will herald developments of Positive Behaviour Support Plans for **all** people with disability who exhibit challenging behaviours, and our recommendation that QCAT be the timely and independent decision maker (as per Justice Carter's recommendation) which would negate the complaint about the delay in decisions, there is no justification for the duration of Short Term Approvals to remain at 6 months**. We therefore propose that the Amendments include a revocation of the amendment of 2010 and return the duration of these orders back to their original 3 month term.** To quote the explanatory memorandum which is headed 'Consistency with Fundamental Legislative Principles') that the extension "*may be considered to have insufficient regard to the rights and liberties of individuals [in accordance with the] Legislative Standards Act 1992, section 4(2)(a)*[5]." Again it states that the actual period for short-term approval "*will be made by the relevant decision-maker (either the Adult Guardian or Chief Executive, Department of Communities, depending on the restrictive practice), on a case by case basis, and based on legislative criteria*."[6] This guideline appears to not have become standard practice in recent times.

Further to this proposal we emphatically counsel the Health and Community Services Committee to include further Amendments to ensure that **no consecutive short term orders** are made as this negates the intent of these orders for interim and emergency circumstances only.

[4] Criminal History Screening Legislation Amendment Bill 2010
[5] Ibid
[6] Ibid

Caveat if amendments go through as proposed

Immunity clauses 17, 22 and 24

Should our opposition to these 'immunity clauses go unheeded, we recommend a legislative requirement -

- That an independent party assesses the need for the short term use of restrictive practices according to strict criteria, within 48 hours of an application being made.

- That the service provider must report on the use of restrictive practices, if approved, within 7 days.

- On how often these 'immunity clauses' can be relied upon, i.e. if service provider is not given consent, there should be no mechanism allowing further application within days of being informed they don't have consent?

- That any approvals under these clauses are retrospective to the day that immunity commenced. This will prevent the use of restrictive practice exceeding the maximum duration of short term approvals.

- That if consent is not given a review is undertaken with the service provider. The aim of the review would be to explore why the service provider believed a restrictive practice was required, and identify areas of training/support to assist the service provider.

- A notice of approval/non-approval is provided not only to the service provider but to the adult and the restrictive practice guardian.

QAI is concerned as to the avenues of address/recourse available **to the adult** if restrictive practices have been used but **not** approved. This is particularly so with Clause 17 as it effectively allows a service provider to arbitrarily deprive the adult of their liberty.

We therefore strongly recommend that all persons subject to restrictive practices must be offered or have access to legal representation. This is particularly important as these amendments presume the adult lacks capacity so it is one thing to give them a statement but another to allow them to be able to exercise legal capacity. This recommendation for legal representation could be incorporated into the statement that is required to be given under Clause 31 regarding the use of restrictive practices.

However there needs to be clarification around when the Clause 31 statement is given, is it prior to the service provider making the application or after? The wording of the clause implies that it be given before application is made – QAI would support this position.

Length of Restrictive Practice Guardian Order Clause 43

Should our opposition to this amendment be disregarded we strongly recommend the adult is **legally represented when the appointment of the restrictive practices guardian is reviewed.**

Transition to new service provider: Clauses 47 & 48

Should our opposition to this amendment be discounted and the amendment is adopted as proposed, we strongly recommend that a review of the need for the use of the restrictive practice be undertaken within 30 days.

1. About Queensland Advocacy Incorporated

Queensland Advocacy Incorporated ('QAI') is an independent, community-based organization providing systemic and individual legal advocacy to people with disabilities. Our mission is to promote and protect the fundamental rights of people with disabilities, extending beyond the defence of civil and political rights to the defence of rights without a legal foundation, including rights to self-respect and dignity. Our organisation has specialist expertise in advocacy for people who live under the application of restrictive practices.

We hold ourselves to account by including people with disability as paid staff, in our membership, and in key board positions. Board members have experience in advocacy, institutional living, community legal services, private legal practice, legal aid, accountancy and community work. QAI is a member of the national Disability Advocacy Network of Australia (DANA) and Combined Advocacy Groups Qld (CAGQ). We endorse and endeavour to uphold the UN *Convention on the Rights of Persons with Disabilities*.

2. About QAI's Human Rights Legal Service

QAI's Human Rights Legal Service (**HRLS**) provides specialist legal advice, representation and referral for vulnerable persons with disability in Queensland. The work of the HRLS is guided by a human rights framework which aims to protect and promote the fundamental human rights of HRLS clients. QAI is uniquely placed to comment on the Bill because we represent people who are or who have been subject to restrictive practices. We have done so since the Carter driven reforms to the *Disability Services Act 2006* and the *Guardianship and Administration Act 2000* in 2008. QAI's relationships with those people subject to the use of restrictive practices has allowed us particular insight into the negative connotations of their use - from honest missteps to serious abuses with tragic consequences. The following vignette is a real life example of such consequences.

3. A vignette to illustrate unfettered use of Restrictive Practices

The lived experience of a young man who has been a client of QAI serves as a litmus test for the post-Carter reforms. This man endured prolonged and unnecessary periods of containment, seclusion and the use of other restrictive practices. He would never have had this experience, if a positive support framework had been used. However his attempts at communication and the effects of his oppressive accommodation environment were considered to be 'challenging behaviours' and he was eventually labelled as 'dangerous' and treated as such by service providers, clinicians and funding bodies.

The service provider strongly advocated that restrictive practices were the **only way** to 'manage this man', to keep him and the community safe. The service provider and the Department of Communities claimed this use was the last resort and least restrictive. However limited concerted effort to determine the validity of the assertion of the need for the use of these practices or to implement alternative or positive strategies was undertaken.

Of interest is that these 'challenging behaviours' most often occurred in his accommodation environment or when he had to return to it after 'leave'. Anecdotally from his supporters they never experienced any such difficulties when he was with them.

Through determined family support and legal advocacy this young man was moved into his own house, where he is now an active member of the community and has set up a small part-time business. However even this process was challenged by the previous service provider and the Department of Communities, Child Safety and Disability Services (The Department), as the new service provider did **not** propose to use restrictive practices.

Concerns stated were that he was a risk to the community and he could only be managed through restrictive practices, in particular 24 hour containment and regular seclusion. Of note is that the new service provider has **not** at any time seen the need for the use of any form of restrictive practice.

This man's story demonstrates that the current legal framework fails to adequately meet its stated purpose to 'protect the rights of adults with intellectual or cognitive disability' or to ensure 'transparency and accountability in the use of restrictive practices'.

Our inclusion of this case study is to assist the Committee to understand QAI's trepidations that the proposed amendments for immunity will allow the service provider to assert the need for the use of restrictive practices (as the last resort and the least restrictive) without any onus of proof.

Further his story illustrates that once a reputation is established be it authentic or not, the process set in place gains momentum and service providers, Positive Behaviour Support Plan (PBSP) writers, QCAT and the Department reinforce erroneous misconceptions about people indefinitely. Statutory bodies, government departments and service providers have a rightful place in supporting vulnerable people with disability but their role is not to oppress or imprison them because of their perceived challenges. This Bill presents opportunities to prevent other people from having similar experiences. It should be noted that this client's experience are not unique.

Guaranteeing that support and every decision about that support is open to scrutiny, and that third parties including family members, Community Visitors, advocates and legal services have access to expeditious processes by which they can challenge those acts and decisions will safeguard and protect people from serious abuse and or harm This aligns with the protective measures as stated in the intent of the Bill.

4. Detailed Submissions

Introduction and QAI Position

The Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2013 arose from a joint review by the Department of Communities, Child Safety and Disability Services and the Department of Justice and Attorney-General into the regulation of restrictive practices under the *Disability Services Act 2006* (DSA) and the *Guardianship and Administration Act 2000* (GAA).

The use of restrictive practices is a serious encroachment on a person's human rights, and therefore they should only ever be used as an extreme last resort, be the least restrictive, have suitable safeguards and be subject to stringent monitoring and oversight. Anything less is inconsistent with the exemplar created by the *Convention on the Rights of Person with Disabilities* (CRPD) that people with disability have the same rights as everyone else. These rights should not be arbitrarily transgressed as the Bill proposes, rather member States have positive obligations to promote, protect and ensure these rights.

Moreover, service providers should have a broad range of resources and strategies of support that must be exhausted before considering such serious measures as applying to use restrictive practices upon a person. Any easing of the current prescriptions demeans and diminishes the serious nature of the use of such restrictions and compounds the risks to vulnerable people with disability.

There is a very real risk that the Bill will lessen the safeguards found in the current legislative framework of the Disability Services Act (DSA) and the Guardianship Administration Act (GAA), resulting in the rights of those subject to restrictive practices being violated; in

particular the right to liberty and security and the right not to be subject to cruel, inhuman or degrading treatment or punishment.

People with disability who live under the application of restrictive practices are powerless. The proposed amendments in particular clauses 17, 22, and 24 would bestow yet more power to those who wield power over vulnerable people despite their purported objective of support.

The Proposed Amendments to the Bill

QAI commends some proposed measures in the draft bill such as the following:

- Statement of rights – clause 31 (s123ZZCA) and clause 37 (s325) the requirement that service providers provide a statement to the adult about the use of restrictive practices, transitional provision retrospective aspect of giving statement.
- Including principles for providing disability services –clause 7 (s123CA)
- Data collection/reporting obligations- 36 (s123ZZJ)
- Increased emphasis on training - clause32 (s123ZZDA
- the broadening of the use of Positive Behaviour Support Plans (BSPs); and Introducing Model Positive Behaviour Support Plans –clause 8
- Improved definitions and examples (clauses 8, 9, 10 &11)
- reduction of prescriptive requirements – clause 13 (s123L)

However, QAI strongly opposes measures that subordinate basic human rights to administrative convenience, including,

- immunity provisions that would authorize up to 30 days use of restrictive practices by the lodging of a form; Clauses 17(s123OA), 22 (s123ZCA), 24(s123ZDA)
- the extension of guardianship appointments for up to 2 years; clause 43
- the validation of the continued use of seclusion or containment by a new service provider clauses 47 & 48

Preamble:

Historical lessons ground the current restrictive practices legislative framework. The Stewart Inquiry [7] and the Carter Report [8] were triggered by proven abuses at places like Basil Stafford and the Challinor Centre. Without legislative protection people with intellectual or cognitive disabilities are vulnerable to cost-cutting expediency, rogue support workers, poor organisational policy and practices, and have little or no recourse.

The people for whom this legislation was written may not be able to express their own wishes or their displeasure, argue their own case or physically defend themselves from unwanted physical advances or restraints. Their position vis-à-vis service providers are subordinate. Amendments to this legislation should always default to the interests of the adults for whom it was originally framed, or run the peril of more deaths and injuries to vulnerable people.

[7] Criminal Justice Commission. 1995. *Report of an Inquiry Conducted by the Honourable D G Stewart into Allegations of Official Misconduct at the Basil Stafford Centre.*
[8] Hon W.J. Carter Q.C. 2006. *Challenging Behaviour And Disability- A Targeted Response*.

Communication:

Many adults with intellectual or cognitive disabilities communicate differently because they are non-verbal or have limited verbal skills or difficulty in expressing or understanding their emotions. So-called 'challenging behaviour' may be one of the only forms of self-expression available to the person: their way of saying 'This is what I want', 'I am in pain' 'I don't like what you are doing', or are communicating their distress about previous incidents or issues. Often this behaviour is interpreted out of context and is presumed to be unprovoked aggression, demanding seclusion and or containment or restraint.

Contrary to conventional wisdom, however, the use of restrictive practices can compound problems with both support and a person's responses.. The research of Carr[9] and of McLean and Grey[10] shows that reduction in the use of physical restraint will reduce behaviours of concern. As the use of restrictive practices are reduced and or eliminated there is a parallel reduction in workplace injuries.

It is widely understood (QAI always starts with this presumption) that understanding a person's behaviour begins by knowing their experiences and how they are being treated. The solution to the reduction of that behaviour also lies in enhancing life experiences and in how they are supported. All citizens should expect that legislative amendments would always aim first to safeguard the person's basic rights, safeguard those around them, and only then ensure operational efficiency.

Restrictive practices should be a last resort:

They should be applied only after every other reasonable resource or strategy available to supporters has been tried, should be the least restrictive alternative, and only used to prevent harm to the adult or others.

"Many deaths of both adults and children have occurred in relation to the use of restrictive practices: Asphyxia and cardiac complications ensuing from the use of restraint are the most frequently reported causes of death. Researchers have also recognised the negative effect of restrictive practices on well-being and quality of life of people who have disabilities (Sigafoos, Arthur, & O'Reilly, 2003; Singh, Lloyd, & Kendall, 1990) as restraint or seclusion often lead to reduced opportunity to engage in daily activities, fewer social opportunities, and social isolation. There is also evidence that restrictive practices can place those implementing them at risk of both physical and psychological harm. Furthermore, restrictive practices can adversely affect the therapeutic relationship between client and clinician. In many cases, the decision to use restriction is made in the absence of adequate consideration of psychological interventions that might mitigate their use."[11]

Reduction or Elimination in the Use of Restrictive Practices:

The Council of Australian Governments is developing a National Framework for Reducing the Use of Restrictive Practices. The framework will provide nationally consistent overarching principles and strategies to guide future work in the reduction of the use of

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[9] Carr, E. G., Horner, R. H., Turnbull, A. P., Marquis, J. G., Magito- McLauglin, D., McAtee, M. L., Braddock, D. (Eds.). (1999). *Positive behaviour support for people with developmental disabilities: A research synthesis*. Washington, DC: American Association on Mental Retardation.

[10] Grey I. M., Hastings R. P. & McLean B. (2007) 'Staff training &challenging behaviour' in *Journal of Applied Research in Intellectual Disabilities.* 20, 1. & Grey I. M. & McLean B. (2007) Service user outcomes of staff training in positive behaviour support using person-focused training: a control group study in *Journal of Applied Research in Intellectual Disabilities,* 20, 6–15.

[11] Evidence-based guidelines to reduce the need for restrictive practices in the disability sector The Australian Psychological Society Ltd. 2011

restrictive practices. The extension of immunity as proposed appears to be in direct conflict with this framework

In QAI's view restrictive practices used as proposed by the Bill would arguably be discriminatory as we are not aware of any other situation where an adult member of the community is subjected to restraint, containment or other restrictive interventions without due process.

Principles: Clause 7

This clause provides the principles for service delivery. Missing from those principles is that every adult has the capacity to change. We should not presume a single instance of behaviour characterises the whole person. While we support the inclusion of these principles we do not support the adverse descriptive statement:

> 'This section applies … *if the adult's behaviour causes harm to the adult or others*.'

We never know that a person's behaviour *causes harm* to themselves or others; only whether it *has caused* harm themselves or to others People's perceptions of the adult are critical to how that adult is treated, and critical to their chances of living free of restrictive practices. The legislation should not perpetuate the misconception that every adult subject to restrictive practices is 'an adult whose behaviour causes harm to the adult or others'. Nor is such a characterization factually correct. Many of these adults have only once caused harm, and even then only in a way peculiar to a particular time and place.

We know in the vignette we provide in this submission, that it was the perception that our client 'causes harm to others' that kept him locked up for years- and yet that same man has now lived without containment for more than a year without any such harm befalling himself or any other.

Meaning of 'Chemical Restraint': Clause 9

The meaning of the phrase 'using medication [..to] *enable* a single instance of health care' (emphasis ours) is open to broad interpretation. 'Enable' (-ing) in the dental example given could include sedation considerably before and after treatment prescribed by a medical practitioner but administered by the service provider. We propose that this wording is reconsidered and that specific conditions are stipulated to prevent circumstances as described.

Plans: Clause 13

We maximise the protection that we provide to people by seeing that (a) their quality of life is enhanced; and (b) that they are in a position where they are able to independently or with support have their needs met in an effective way. The plan must never lose site of the goal - that is, a reduction in the future need for restrictive interventions.

QAI supports the proposed reduction in legislative requirements for PBSPs. In addition we believe this section should include provision for:

1. an executive summary,
2. reduction strategies,
3. early warning signs and triggers
4. safeguards that must be taken while the restrictive practice is in use; and
5. timeframes for review.

It is crucial that the Plan has stated goals with time frames, strategies for implementation and desired outcomes. The purpose of the Plan is to guide support staff towards a reduction

and elimination of triggers and responses that become behaviours of concern. The strategies employed assist the person towards an increase of replacement skills. Baseline requirements for PBSPs are included in the Australian Psychological Society's 'Minimum Standards for a Positive Behaviour Support Plan'. [12]

Goal summary: The legislation should mandate an executive summary of goals. The summary should include a description of how effective the support strategies are in the present, and reflect an accurate description at the end of the timeline. Plans tend to be an accumulation of much data and are broadly written, making it difficult to identify future actions, namely the (action) Plan itself. .

Immunity provisions: Clauses 17, 22 & 24

When the restrictive practice framework was introduced in 2008 service providers were given an extended immunity- a **transitional** arrangement that was phased out on 31 March 2011. Restoring immunity for administrative convenience or to relieve resource burdens is an offence to the rights of those subject to these practices. The focus of change should be on administrative reform, not on punishing the adult, which is effectively what these clauses do. The Bill as it is proposed defeats one of the objectives for its introduction- enhancing the protections for the adult subject to restrictive practices.

The Explanatory Notes state these clauses are in part a response to service provider concerns about delays in obtaining approval to use restrictive practices. According to Ms Claire O'Connor, delays occur because:

- the decision maker may need further information;
- the decision-maker may need to seek further professional advice; or
- there is a backlog of applications in, for example, in the Adult Guardian's office.[13]

Service providers currently have immunity from civil or criminal liability if they use restrictive practices in accordance with the approval or consent, a positive behaviour support plan, providing they act honestly and without negligence. [14]QAI acknowledges the concerns expressed by service providers about the consequences of not receiving timely approvals. QAI also recognises the status quo must change, but this change should not be to the detriment of the rights of those subject to restrictive practices.

Therefore it is important that the current legislative impetus to reduce the use of restrictive practices is not weakened, rather strengthened. The proposed immunity provisions are permissive and therefore have a retroactive and weakening effect on the protection that the current legislative framework affords to those who are subject to restrictive practices. Such an approach is contrary to the recommendations of the Carter report and indeed the intent of the legislation itself. They are permissive because there effect is to allow a service provider to use restrictive practices with immunity from civil or criminal liability for up to 30 days, **without consent,** whilst waiting an approval from either the Adult Guardian or Chief Executive of Disabilities. Ostensibly these amendments are for reasons of administrative convenience and resource constraints and are responsive to the perceived needs of service providers. As such they fail to either adequately protect the rights of or enhance safeguards to those adults subject to restrictive practices.

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[12] The minimum BSP requirements are set out in Appendix B of Budisilek *et al* . 2011. *Evidence based guidelines to reduce the need for restrictive practices in the disability sector.* APS.
[13] Claire O'Connor in *Hansard* - Health And Community Services Committee Public Briefing—Disability Services (Restrictive Practices) And Other Legislation Amendment Bill 2013, Transcript Of Proceedings. Thursday, 5 December 2013 Brisbane, page 8.
[14] Disability Services Act 2006 (Qld) ss 123ZZB, 123ZZC

Of particular concern is clause 17 because this clause allows a service provider to detain a person without an order or independent scrutiny which conflicts with our system of law and justice and is disproportionate with Queensland 's (and Australia more widely) human rights obligations.

It is important to recognise that to date no service provider has been prosecuted **even when the use of restrictive practices has not been approved**. Therefore the lobbying for this extension of immunity provisions is overstated and is not necessary, and has serious implications for the person at the heart of this legislation.

During the public hearing on 17 December 2014 Dr Douglas MP asked the QAI representatives the following question: 'If the immunity provisions are not reasonable, no-one will look after these people. Are you aware of that?'[15]

We now respond with these points for your information and consideration:

- These are not people who have committed a crime, yet we are considering measures that deprive people of basic freedoms.

  In *Chu Kheng Lim v Minister for Immigration* (1992) 176 CLR 1, 27-28,, Brennan, Deane and Dawson JJ said *that, putting to one side the power of the legislature to punish for contempt and of military tribunals to punish for breach of military discipline, and the exceptional cases of mental illness or infectious disease which are non-punitive in character, involuntary detention of a citizen in the custody of the State is penal or punitive in character.*

  In *Kable v DPP* (NSW) (1996) 189 CLR 1, 55, Gummow J cited the remarks of Gaudron J in *Chu Kheng Lim*:-

  Detention in custody in circumstances not involving some breach of the criminal law and not coming within well accepted categories of the kind (referred to above) is offensive to ordinary notions of what is involved in a just society.

- Adults with cognitive or intellectual disabilities are entitled to due process like any other. The *Mental Health Act 2000* and criminal procedure require process and scrutiny before providing immunity to medical and law enforcement officers.

- In answer to the question raised by Dr Douglas, should a service provider be unable to deliver the support as required, and threaten relinquishment of the person, there should be a review of the appropriateness of their appointment and another service provider sought rather than acquiescence to the request for the use of restrictive practices.

- We reiterate, that there has **never** been a service provider prosecuted for the use of restrictive practices whether they have been approved or not.

We ask committee members to consider how similar immunity provisions could apply to loved ones, be they children or elderly parents. Would you agree for your loved ones to be supported by people against whom they had no remedy if assaulted? In our view there must some form of legal recourse for vulnerable people who are at the control and whim of others purported to be charged with their support and care.

Summary of QAI's Immunity Objections:

[15] At the public hearing before the Health and Community Services Committee on 17 December 2013 .

- The proposed extended immunity is unnecessary, forgoing the liberty and the quality of life of people with disability so that service providers can be secure against litigation, and so that the relevant decision maker has more time to make a decision.
- They are a retrograde step - a return to a more permissive approach to the use of restrictive practices.
- Rights to civil and criminal remedies for assault, false imprisonment and so on are fundamental to citizenship; and it is discriminatory to deny people with disabilities those rights.
- The common law Doctrine of Necessity [16] and workplace health and safety legislation already offer workers and service providers protections.
- No other state or territory provides legislated immunity without scrutiny.
- Immunity without conditions is not consistent with the proposed new purposes of Part 10A stated in Clause 5. These purposes include regulating the use of restrictive practices in a way that-

  (a) 'has regard to the human rights of those adults; and
  (b) ' *ensures transparency and accountability* in the use of restrictive practices'

- Pursuant to Clause 17, a service provider may apply to use any form of containment or seclusion specified on a plan which they *may themselves have devised,* and knowing that they may apply that practice without further justification for 30 days.
- It appears that a service provider may make consecutive 30 day applications.
- Allow a service provider to use restrictive practices simply by lodging an application with the Adult Guardian or Chief Executive
- Suspend fundamental legal protections available to all other citizens.

QAI **recommends** that rather than extend existing immunity, the decision maker should be mandated under legislation to **make a decision with 48 hours** of receiving an application on whether or not to approve an interim use of restrictive practices. The length of this 'interim order' should be no longer than 30 days and be conditional that any further information required should be provided within a specified period (7 days). Prior to the end of the 30 days, or on receiving this additional information the decision maker either revokes the interim order or makes a short term order. The duration of any interim order should be considered as part of the duration of any subsequent short term order.

[16] The common law Doctrine of Necessity is set out in *Re A (Children) (conjoined twins: surgical separation)* [2000] 4 All ER 961 at 1052. It has three conditions:

1 the act in question is needed to avoid inevitable and irreparable evil;
2 no more should be done than is reasonably necessary for the purpose to be achieved;
3 the evil inflicted must not be disproportionate to the evil avoid.

Emergency care workers can provide care to a patient where it is necessary to:
(a) save the patient's life, or
(b) prevent serious damage to the patient's health, or
(c) prevent the patient from suffering or continuing to suffer significant pain or distress.
The Doctrine applies outside of emergency or life-saving treatment where a patient requires care but is unable to give consent: for instance, where there is a necessity to act when it is not possible to communicate with the patient, and where the action taken is reasonable in all the circumstances and is undertaken in the best interests o the patient irrespective of the cause of their inability to give or refuse consent for treatment. If these conditions are met then no legal action should arise as a result of treatment and/or transport being undertaken without the patient's permission.

Such an approach ensures consideration by the decision maker as to the appropriateness of the restrictive practices allows the service provider to use the restrictive practice without fear of civil/criminal liability and provides for collection of additional information.

Decision maker:

The administrative reasoning behind the need for immunity is based on purported delays in decision making, the quality of decisions and conflicts raised about the relationships between the Department and service providers.

Concerns have been raised regarding overburdening on the Office of the Adult Guardian and the capacity of individual guardians to make wise and informed decisions. Anecdotal evidence to hand has highlighted a propensity for some service providers to hold the Chief Executive to ransom.

Justice Carter recommended that all decisions for the use of restrictive practices be made the by Tribunal (referring to the Guardian and Administration Tribunal – now Queensland Civil and Administrative Tribunal (QCAT). We support Carter J's recommendation that emergency, interim and longer term approval for both plans and restrictive practices should go to the Tribunal. Carter J suggested that a plan requires the approval of GAAT, and the application for approval by the service provider will require the submission of material in support of the use of the restrictive practices sought as part of the plan; the *jurisdiction of GAAT can be accessed in an emergency and should include the power to make an interim orde*r.[17]

Therefore a competent and neutral third party would be the most appropriate, and effective instrument for making decisions about such a serious and important matter delivered in the timeliest fashion. We believe that QCAT fulfils this obligation.

This recommendation goes in hand with our position that once decisions are independent and timely there is no need to extend or approve proposed immunity amendments.

Monitoring and Data Collection - Clause 36

We support this amendment with the following riders.

- There must be more transparency. De-identified data should be placed in an accessible register to facilitate a better understanding of strategies.
- Information should not lie with the Department of Communities but with an independent body such as the Centre of Excellence.
- The language of the bill at 123ZZK should be mandatory, that is 'must' (not give).

De-identified information should be publically available so that anyone can make informed judgements about what works and what does not. Plans should be audited for quality so that we can identify which strategies work and which do not. Victorian research mandated by their legislation includes the collection and analysis of data on positive behaviour support. That research shows that there is a clear relationship between the quality of plans and the reduction of restraint and seclusion.[18]

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[17] Hon W.J. Carter Q.C. 2006. *Challenging Behaviour And Disability- A Targeted Response*. p 153.

[18] According to Dr Lynne Webber, speaking at 'Human Rights v Restrictive Practices' (seminar convened by QAI 28 August 2013. Webber and colleagues (2011) demonstrated how the quality of behaviour support planning and staff understanding of its functions can affect the use of restrictive interventions in disability services. Webber, L., McVilly, K., Fester, T., and Chan, J. (2011) 'Factors Influencing Quality of Behaviour Support Plans and the

Increasing the length of guardian appointment - Clause 43

This clause refers to the length of time QCAT can appoint a restrictive practices guardian. This amendment is proposed in response to service provides concerns about the resource intensive nature of the process for appointing and reviewing the appointment of a restrictive practice guardian. Service providers state this diverts resources from care of clients.

From QAI's experience we fail to see how the review of a restrictive practice guardian is in any way resource intensive for the service provider. The only time it may be is when service providers challenge the appointment of a particular guardian, usually family members. Often these reviews are held on the papers, which are preceded by a written request from QCAT to comment on the appropriateness of the guardian.

QAI is opposed to this amendment on the following grounds:

- Implied presumption that restrictive practices are required for two (2) years,
- Increasing the length of appointment from one to two years provides no direct or positive benefit to the adult.
- There is a real possibility due to the effect of Clauses 13 & 29 that the restrictive practices guardian access to information may be diminished.
- The amendment is for administrative and resources convenience.

Should our opposition to this amendment be ignored we strongly recommend the adult is legally represented when the appointment of the restrictive practices guardian is reviewed.

Transition to new service provider: Clauses 47 & 48

This amendment is sought to allow a service provider who will be providing services to an adult, where the use of seclusion and containment is needed to keep the adult or other safe from harm, to apply for approval so that it is in place when the adult starts receiving service from the new service providers. This would be in situations when the adult is moving from one service provider to another.

QAI is alarmed with this amendment as it has the potential to label a person as requiring restrictive practices in all environments and circumstances. That is the person's alleged reputation may unfairly precede them. This amendment effectively removes the requirement for a service provider to undertake their own assessment as to whether restrictive practices are warranted. This is of considerable concern because the original approval has been given for a particular set of circumstances and could not and should not be reconciled to apply in a new environment (refer to case example above).

QAI recognises not all service providers would use this provision; however its inclusion diminishes the safeguards currently afforded to those who are or could be subject to restrictive practices. Again this amendment appears driven by service providers desire for expediency with little regard to the rights of the person affected.

QAI recommends this clause be removed from the Bill.

Impact of Plan Quality on Restrictive Intervention Use', *International Journal of Positive Behavioural Support,* 1(1): 24-31.

Queensland Advocacy Incorporated
Systems and Legal Advocacy for vulnerable people with Disability

Health and Communities Committee,
Parliament House,
George Street,
BRISBANE. Q. 4000

Friday 10th January, 2014.

Dear Members,

Re: proposed amendments to the *Disability Services Act 2006* and Guardianship and Administration Act 2000

Further to our submission of yesterday's date, we would like to offer the following additional information for clarification and consideration.

This information is in relation to individuals with disability who present with first time instance/s of behaviours that are perceived to be challenging to a service provider. This occurrence is most likely to arise in "exceptional circumstances", such as change of service provider, moving location or due to experiences of tragedy or trauma.

We propose that should this situation arise that the service provider makes application for interim emergency orders for the use of restrictive practices for a maximum of 30 days in order to assess the person's support needs, develop Positive Behaviour Support Plans and a decision be made within 48 hours maximum. Please refer to our recommendation at the bottom of page 15 of our initial submission.

Yours sincerely,

[redacted]

Michelle O'Flynn
Acting Director

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