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

22nd January 2014

Submission re: restrictive practice

The point of this submission is to demonstrate flaws in the current legislation and how the legislation can be used negatively and so be detrimental to the people it is supposed to protect.

This submission is based on personal experience whilst attempting to advocate for ██████████.

His story is best told in his own words and illustrated by his drawings and letters and photographs of the 'community accommodation' at Wacol where he was housed at various intervals throughout his years under Disability Services Qld. Panel members are able to view a video of his story on a Youtube site ██████████ to gain better insight into a range of problems and the effect on vulnerable human beings when the system has failed them. His story is further explored through a series of de-identified case studies presented as submissions by QAI. (Qld Advocacy Incorporated). The de-identified case studies highlight his/our journey through the restrictive practices process, guardianship applications, attempts to change service provider, PBS plans and the role taken by disability services and SRS in the QCAT process.

Another perspective of his story comes from the current service provider that now manages him without restrictive practice, the descriptions of their experiences when trying to take over his care at that time, was presented at the restrictive practices forum in Brisbane last year. I believe as did others at the forum that their presentation gives validity to our gravest concerns about way restrictive practice is applied within Queensland. Their experiences and observations of his previous care conditions provide an alternative perspective which supports the studies presented by QAI, the barrister and university advocates who support our family and the many others not named in the forums. The process has been documented and peer reviewed and shows that the PBS (positive behaviour support plan) written by the SRS and service provider, supported by DSQ and approved by QCAT over several months was harmful to ██████████ in a manner that breached the human rights convention on torture on many fronts. This is fact

Further complaints were made during the tribunal process that physical, emotional and possible sexual abuse in the care of the service provider was occurring and that a complaint had been made to the police. To this date there has been no investigation of any of the complaints by any of the organisations tasked with protection of vulnerable people in care. ██████████ suffers terribly with the

memories of his experiences at this time. His stories of abuse and torment are being recorded by his current service provider.

During the tribunal process the credibility of our entire family was called into question at this time which added further distress to our situation and moves were put in place to discredit us by presentation to the tribunal of false evidence on the basis of hearsay and biased reporting. This was accepted by QCAT. Onus of proof was not a requirement.

Submissions made by the services were allowed to be submitted so late that our family and legal representatives had no time to view them before going into the tribunal. Therefore our ability to state our case in favour of [REDACTED] was severely disadvantaged as we spent most of our time attempting to defend unsupported assumptions of our care intentions for [REDACTED]. QCAT allowed this and allowed statements by representatives from the Office of the Adult Guardian. These representatives spoke about members of our family despite never having met us prior to the day. My application for guardianship of [REDACTED] was denied because of the conflict between myself, department, service provider and SRS over the nature of care on the basis of the advice given by this person. The only advice given to the office in regard to our family was given by the people we were in conflict with and no attempt after the application had gone in, was made by the Office of Adult Guardian to contact us and hear the concerns we had in relation to [REDACTED] care or the misgiving his advocates had about the nature of the PBS plan or the ability of the SRS team to see the that what they were preparing was indeed a plan for the perpetual containment, without therapy or realistic treatment to secure his eventual release from the process. It was a wholly biased process. Our family have since been exonerated by peer reviews conducted outside this process. The basis of our conflict was and still is valid. [REDACTED] successfully applied for guardianship but was given unprecedented responsibilities to the extent it became a full time job and she had to give up full time paid work to cope with it all. She became pregnant during this time and the stress in dealing with QCAT, OAG, SRS, DSQ service providers, lawyers worried us all.

I cannot stress enough the vital role legal advocacy plays in the protection of people placed in restrictive practice. Each person regardless of capacity and especially when under the protection of the Adult Guardian should/must have legal representation. Any form of advocacy outside the care system should be welcomed and supported. Disability services, care services of any nature should not be allowed to claim ownership of a client to protect their methods of service delivery from scrutiny.

[REDACTED] during the period described above became a business commodity. Funding is allocated for challenging behaviour. The worse the behaviour the more funding is allocated. For a service provider this allows no incentive to improve the situation for the client. In fact where a service provider operates for profit and without sufficient scrutiny the opposite can apply.

I believe our case has highlighted the flaws in the PBS plans. Showing how they can/ could be written in such a manner as to keep a person with high funding needs continually locked into an unsuitable model of care. This is my experience of [REDACTED] plan. It's easy to write minor improvements in behaviour into a plan without anyone checking the validity of the information. Minor improvements in written information rarely translate to an improved quality of life for the client. Pieces of [REDACTED] plan were cut and pasted from another clients plan and presented to QCAT with the other persons name still plain to see. Our input as a family was rejected outright by the service provider. Our doctor of choice was replaced by the service provider. Our choice of service provider was rejected by the service provider and also, supported by DSQ. The medication review under DSQ Dr did not take place except on paper. All specialist services were documented on paper

only eg; speech pathology, occupational therapy, psychology, as SRS specialists are not required by the department to practice their occupation with their clients. Therefore despite documentation to the contrary no client in the history of the department has been treated by a DSQ employed SRS specialist or nurse. As they are not allowed to. Therefore, the questions I have in relation to this knowledge are;

How can any advice they proffer in the care of clients be legitimate?

Where does their expertise in the field come from given that the only place in the system apart from jail where this category of clients reside is within the department?

Given that there has been no clear records or data kept regarding treatment models for clients what precedents and information do they rely on for the justification of their opinions?

Until very recently DSQ specialists did not have educated mentors to guide them in their care principles for the general disability population let alone this category of clientele. DSQ did not require them to be registered under a legitimate professional body during our time with them was this not a blatant breach of duty of care?

How did the SRS teams suddenly develop the capabilities to advise; DSQ, Office of the Public Advocate, QAI, the Office of the Adult Guardian, doctors and other clinicians, the ministry, members of the community, law enforcers, judges and law makers etc, etc, in a manner that implies superior knowledge of their clients?.

How can that be possible when contact with clients they represent is so minimal and totally irrelevant to their real needs?

How can it be possible to advise others in a professional capacity when they do not and never have practiced their qualification in a therapeutic way for their clients?

When restrictive practice has been the only method of care for some clients (no other treatment method has seriously been attempted except in an ad hoc, hit or miss fashion, without credible ongoing evidence based supporting data), isn't this guaranteeing the failure of the client to succeed under such care models?

Just as importantly doesn't it demonstrate an admission of failure by professionals to expand their knowledge and suggests that expertise in the field is extremely limited across the board?

Academic knowledge alone does not equate to experience or the development of practical skills. Without practical application of skills and testing of theories no knowledge can be relied upon to convey an accurate assessment of any situation. It remains always as unsupported opinion only. Carers following plans devised in this way are put at risk, clients are further disadvantaged. Failure of the system to accurately represent the clients should never be seen as failure of the client to be never able to improve. Does this happen because designers of care models often fail to recognise that the care model itself is at fault?

Self reflection, by care services delivering care practices is often factored out of the assessment process and poor practices often severely disadvantage clients by blaming them for failings of people servicing them. Why is that?

Even after many decades of funding for these type of services, nothing has really changed for the better for these clients eg; clients are still forced to reside at the Wacol precinct. They are still

extremely vulnerable, marginalised and socially stigmatised by the design of the care models and the environment.

Why do facilities like Wacol exist for the disabled when so many other proven examples of humane care models e work better? Cages for human beings while kangaroos sit outside? Animals watching humans in the zoo? The disability precinct at Wacol is not a community centre. Staff were trained in take down methods, care models based on punitive not therapeutic models. Documentation emphasises negative not positive aspects of the client. Social isolation and boredom because of meaningless activities keep clients frustrated and fearful in what is supposed to be (according to DSQ) a home environment. People remain in a state of extreme duress cannot respond in a positive way to assessment. How can they?

While we were there no medication review was ever completed therefore the possibility that side effects of over medication or inappropriate medication may have contributed to a worsening of his epilepsy and associated behaviours has never been determined. We still cannot get a medication review it seems Drs have no problem giving medication but have enormous problems taking it out. There has been no improvement in [REDACTED] condition on the medication regimes and over the years his epilepsy worsened in care. His IQ level dropped and he lost many skills. He is currently relearning some of these skills with a great deal of success.

What replaced Basil Stafford when it was renamed offers nothing better to the people who reside there now than before the days of the inquiries and reports into abuse at the site. I believe without proper scrutiny of the site clients are far more at risk now than ever. It is the worst type of institutional care imaginable despite the denials by DSQ that this is an institution it continues regardless in the manner it always did, in a less obvious way to outsiders than in the past.

The entire Wacol precinct has become in the last decade the dumping ground for societies unwanted, even the RSPCA has claimed a spot for unwanted pets clients are more vulnerable than ever. Who really cares?

The Adult Guardian is the decision maker in this case for most of the residents under restrictive practice at the Wacol precinct. The community visitor presents regularly and is supposed to provide added protection for clients. If little has changed in real terms for the client what has gone wrong? Is it wise for community visitors recruited from the police force to visit such sites and be expected to give unbiased opinion on conditions there when his past experiences involved putting people into restrictive environments? How in his judgement would he think what was happening to clients there was wrong?

I emphasise the point the clients I refer to are not clients under forensic orders but people who have been processed through the disability sector without having their needs met in a way meaningful to them, but have been provided a service to suit the convenience and funding models of the services contracted to provide care.

We are fortunate to have found a service provider that practices its mantra of social justice with integrity. We are grateful to the legal advocates who assisted us out of the restrictive practice debacle and continue to support us and the core values we hold dear.

[REDACTED] is growing and learning to be within a supportive community. He still fears carers and distrusts doctors and specialists at this stage. He questions the loyalty of his family and why we left him there as long as we did. He doesn't understand the complications of the process, nor did we at the time. We were uncomfortable and intimidated during the entire process without legal support we could

not have coped with what was happening. In the end it was not QCAT who helped [REDACTED]. We are grateful to be out of that system now.

One final comment I would like to make is that [REDACTED] case was one of the cases reviewed by judge carter prior to the publishing of the carter report. [REDACTED] case is still being highlighted many years on in other forums as a person who represents the failure of this system to ensure the safety and human rights of people in care.

Is it fair that he should have to shoulder that responsibility in order to bring attention to all others who cannot represent themselves in similar situations?

Despite all that focus, with all that money, with all the so called momentum for change after all the inquiries and reports detailing system failures. He was harmed further under the new laws.