Office of the Public Advocate
Systems Advocacy

Submission to the Health and Community Services Committee

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

December 2013

Queensland Government

Public Advocate

The Public Advocate was established by the *Guardianship and Administration Act 2000* to undertake systems advocacy on behalf of adults with impaired decision-making capacity in Queensland. The primary role of the Public Advocate is to promote and protect the rights, autonomy and participation of Queensland adults with impaired decision-making capacity (the adults) in all aspects of community life.

More specifically, the functions of the Public Advocate are:

- Promoting and protecting the rights of the adults with impaired capacity;
- Promoting the protection of the adults from neglect, exploitation or abuse;
- Encouraging the development of programs to help the adults reach their greatest practicable degree of autonomy;
- Promoting the provision of services and facilities for the adults; and
- Monitoring and reviewing the delivery of services and facilities to the adults.[1]

Through our work, we estimate that there may be up to 114,000 people with impaired decision-making capacity in Queensland.

Approximately a quarter of these people have an intellectual disability, and a further 15% have a cognitive impairment. Our estimates also suggest that approximately 20% of the potential population access specialist disability services.

Position of the Public Advocate

The Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2013 (the Bill), contains the legislative amendments proposed as a result of a review of the regulation of restrictive practices in the *Disability Services Act 2006* and the *Guardianship and Administration Act 2000* conducted jointly by the Department of Communities, Child Safety and Disability Services and the Department of Justice and Attorney-General.

The regulation of restrictive practices applies to people with intellectual disability or cognitive impairment who access specialist disability services that are funded by the Department of Communities, Child Safety and Disability Services.

While not all people with intellectual disability or cognitive impairment exhibit behaviours that would result in them being subject to restrictive practices, those that do represent a significantly marginalised and vulnerable group of Queenslanders and the proposed amendments have the potential to impact many such Queenslanders.

The use of restrictive practices is a significant infringement on a person's human rights, in particular the right to liberty and security of the person and the right not to be subject to cruel, inhuman or degrading treatment or punishment. It is also potentially unlawful and may give rise to criminal or civil liability. It is therefore imperative that restrictive practices are only ever used as a last resort, that appropriate safeguards are applied and that there is appropriate monitoring and oversight of their use.

Understanding behaviour: the person is not the problem

It is important to understand that 'challenging' behaviours are not a 'failure' of the person exhibiting them; they are a failure of the system around them. Similarly, it must be understood that 'challenging' behaviours are titled as such because they are challenging for the service provider or those supporting the person. In most instances, they are not challenging for the people themselves.

At its essence, behaviour is functional in nature; it serves a purpose.

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[1] *Guardianship and Administration Act 2000* (Qld) s209.

For many people with intellectual disability or cognitive impairment, behaviour is a means of communication. It is their way of saying to those supporting them that they are in pain, or that they are upset. Or they may be saying that they are confused, anxious, sad or overwhelmed.

It could be any number of things that the person is trying to convey but if the people supporting them do not understand what makes the person 'tick' and/or have not learnt to speak their 'language', then ultimately the person's needs are not understood. Many of the people being supported by disability service providers have experienced years of not being understood. They are supported with people they do not like or they are forced into 'institutional-type' routines that do not fit their own lifestyle preferences.

For many people with intellectual disability or cognitive impairment who exhibit 'challenging' behaviours, their behaviours may have arisen from a single instance of not being understood. For some this may have originated when they were a child with a family who, despite trying their hardest, couldn't understand the 'language' that their child was speaking. For others, it may have started when they were at school, and then started generalising into other areas of their life. For many, almost contrary to belief, it begins when they start accessing specialist disability support services.

> Consider for example a person who tries to communicate to someone working with them that they want to be left alone only to find that the support staff doesn't do so. The person may then try to push them away, or may turn their back to walk away themselves. But again, the support staff may persist in interacting with the person. As with any of us, the person is likely to become increasingly agitated if they try in many and varied ways to be understood with no success. Ultimately, this escalation may lead to a person lashing out physically... and so the label of having 'challenging' behaviour is established.
> If only the support staff had understood what the person was trying to tell them in the first instance; the future for such a person would be quite different.

Consistent with the paradigm shift that the United Nations *Convention on the Rights of Persons with Disabilities* has elicited with respect to understanding that disability results from the interaction between people with impairments and their surroundings as a result of attitudinal and environmental barriers,[2] so too should we approach our understanding of 'challenging' behaviour. Behaviour must be understood within the context of the environmental factors that exist around the person.

For a person with an intellectual disability or cognitive impairment, as with any of us, it does not take long to 'learn' what works and what does not in terms of achieving the outcomes that they are seeking. It should not come as a surprise, therefore, when a person starts to increasingly rely on the 'challenging' behaviour as the first resort option in seeking to have their needs met. After all they have been 'taught' by others that this is what works.

This scenario occurs every day in disability support services, it occurs every day in families. It is for this reason, that I wholeheartedly support an increasing focus on positive behaviour support.

At its essence, positive behaviour support is about seeking to understand why a person engages in the behaviours of concern and, in doing so, how to avoid the 'triggers' that may prompt the person to engage in these behaviours. It is about acknowledging that the person is not the problem.

Focus of the review

Queensland's restrictive practices regulatory regime was introduced in 2008 as part of a broader system reform aimed at reducing and eliminating the use of restrictive practices. Central to the reforms known as Positive Futures was a focus on positive behaviour support.

Prior to the introduction of the Positive Futures reforms, there were grave concerns expressed in the Report by the Honourable WJ Carter, *Challenging Behaviour and Disability: A Targeted Response* (the Carter

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[2] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007 [2008] ATS 12 (entered into force 3 May 2008) ('*Convention on the Rights of Persons with Disabilities*').

Report)[3] about the disability sector's over-reliance on practices such as restraint and seclusion to manage people with intellectual disability as well as concerns "that these practices, which have no legislative support such as can be found in the Mental Health Act for the proper care of those with mental illness, are unlawful or at best are supported by legal paradigms which are of doubtful validity".[4]

The recommendation for a legislative framework to provide lawful authority and safeguards for the use of restrictive practices in the Carter Report was but one of many recommendations aimed at "a fundamental process of reform, renewal and regeneration of the DSQ and disability sector's response, which will provide an efficient, cost effective and financially sustainable outcome for the proper care and support of persons with intellectual disability and challenging behaviour across Queensland".[5]

The range of reforms recommended by Justice Carter and adopted by the Queensland Government included a new individualised approach to working with people with intellectual disability or cognitive impairment and challenging behaviours that involved comprehensive multi-disciplinary assessments and individualised positive behaviour support; a Queensland Centre for Best Practice in Positive Behaviour Support whose role would include research, community development and education; recruitment and development of qualified allied health and support staff; and the establishment of a range of accommodation options including community living for the target group.[6]

It has been five years since the introduction of the regulatory regime and the other systemic reforms aimed at reducing restrictive practice use in the disability services sector in Queensland. Given that the broad service system and legislative reforms introduced following the Carter Report were designed to provide an integrated legislative and practice response in which each of the respective elements complemented and supported the success of other elements, I was concerned that the focus of the review of the reforms that have led to this Bill was so narrowly defined and targeted primarily at the regulatory regime, in particular on opportunities to 'streamline processes and reduce red tape for disability service providers'.

I am particularly keen to ensure that this focus on the broader practice and system initiatives aimed at building the capacity of the sector to implement positive behaviour support approaches to reduce and eliminate the need for restrictive practices is not lost.

Policy objectives of the Bill

The Explanatory Notes to the Bill state that the review of the legislation identified a number of opportunities to:

- Improve the care and quality of life for adults with challenging behaviour;
- Enhance protections for these adults; and
- Streamline processes and reduce red tape for disability service providers.[7]

Overall, I am supportive of this intent, qualified by the view that any streamlining of processes should not reduce safeguards for clients. I am concerned however that in many instances the Bill does not achieve these objectives. I am also concerned that the Bill is heavily weighted in favour of the last objective that is to 'streamline processes and reduce red tape for disability service providers'.

Improving the care and quality of life for adults with challenging behaviour

The Explanatory Notes state that the Bill achieves the policy objectives (broadly related to this aim) by:

- Emphasising the need for a positive behaviour support approach for all adults with intellectual or cognitive disability and challenging behaviour in funded disability services not just where restrictive practices are required.

I wholeheartedly support this objective.

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[3] W J Carter, *Challenging Behaviour and Disability: A Targeted Response* (Report to the Queensland Government, 2006).
[4] Ibid 147.
[5] Ibid 9.
[6] Ibid 10.
[7] Explanatory Notes, Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2013 (Qld) 1.

Currently the positive behaviour support plan is inextricably linked to the use of restrictive practices, to the extent that a comment often made is that the positive behaviour support plan is seen as one of the prerequisites to use restrictive practices.

This Bill introduces some important new principles about providing appropriate support to all people with intellectual disability or cognitive impairment who exhibit behaviours that harm themselves or others, regardless of whether the service provider is seeking to use restrictive practices, including mandating the use of a positive behaviour support approach.

There are a number of suggested amendments in the body of this submission that could assist to better achieve this objective.

Enhancing protections for these adults

The Explanatory Notes state that the Bill achieves the policy objectives (broadly related to this aim) by:

- Outlining that service providers should not use restrictive practices as a form of punishment;
- Providing for reporting on the use of restrictive practices by funded disability service providers to enable systematic monitoring of the use of restrictive practices and improving outcomes for adults;
- Introducing a requirement for service providers to provide a statement to the adult and those close to the adult about the use of restrictive practices to enable them to understand the framework, avenues for complaints and redress, and how they can participate in planning and decision making.

These reforms are also most welcome, and in the case of reporting, well overdue. While legislation might state important principles about the use of restrictive practices, the sector requires ongoing intensive support, including clinical support, to implement these practices in an appropriately balanced way with due regard for human rights and, in doing so, elicit the necessary cultural shift. There also must be ongoing monitoring and evidence-based approaches to assessing the efficacy of the current legislative and service system initiatives, as well as the clinical efficacy of the positive behaviour support plans themselves.

This submission outlines a number of strategies that should be implemented to support the important principles introduced by this Bill.

Streamlining processes and reducing red tape for disability service providers

The Explanatory Notes state that the Bill achieves the policy objectives (broadly related to this aim) by:

- Amending the definitions of restrictive practices to clarify that the purpose for which restrictive practices are used is to respond to the behaviour of an adult with an intellectual or cognitive disability that causes, or has the potential to cause, physical harm to the adult or others. This will make it easier to determine the practices that require authorisation;
- Reducing the prescriptive requirements in positive behaviour support plans to ensure that plans only contain detail that is useful for service providers in providing care and support to the adult;
- Providing flexibility in appointment periods for guardians for a restrictive practice matter from a maximum appointment of up to 12 months to up to 2 years to allow service providers to focus more of their resources on the care of clients;
- Removing the requirement for a short term plan for a short term approval to reduce the regulatory burden associated with seeking a short term approval;
- Clarifying when a short term approval can be sought to support the transition of adults subject to the regulatory framework to new service providers;
- Providing time-limited immunity from civil or criminal liability where a service provider has sought a short term approval, or the consent of the Adult Guardian as a guardian for a restrictive practice matter, and the approval or consent has not been decided before the existing approval or consent expires to ensure that service providers are not at risk of using restrictive practices without immunity from civil and criminal liability;

- Clarifying that the use of medication such as a sedative to facilitate the provision of a single instance of health care, such as dental work, to an adult with an intellectual or cognitive disability is not a chemical restraint; and
- Removing the legislative requirement for the Department of Communities, Child Safety and Disability Services and service providers to keep and implement policies on the use of restrictive practices, as the requirement for these policies will be dealt with administratively and will continue to be monitored through the department's Human Services Quality Framework. The removal of this requirement eliminates some unnecessary complexity from the legislation, without compromising client safeguards.

I acknowledge and respect the views of service providers that have worked collaboratively with the Department of Communities, Child Safety and Disability Services since the introduction of the regime, and indeed I commend their efforts in seeking to implement a positive behaviour support approach and consequently improve the way in which they support their clients. Anecdotally (although unfortunately there is no data or evidence to support this view), the use of restrictive practices in the sector has declined and the sector has a much better understanding of how to work constructively and positively with people with intellectual disability or cognitive impairment and behaviours that cause harm to themselves or others. This is to be commended.

Initially, these legislative and practice reforms were a significant change for the sector. When the legislative framework first commenced in July 2008, service providers were provided with an 18 month period in which they had immunity to continue to use restrictive practices (as long as certain minimum requirements were met) while they became compliant with the full requirements of the legislative regime. This 'transition period' was extended by making amendments to the *Disability Services Act 2006* on two occasions, with the final 'transition' period ending on 31 March 2011. From this time onwards all funded service providers were expected to be fully compliant. That is, restrictive practices could not be used without an effective consent or approval and the development and implementation of a positive behaviour support plan.

It is important at this stage of the implementation of the legislative framework, not to take a backwards step. This is why it is disappointing to see a return to the approach of providing immunity to service providers to use restrictive practices without an effective consent, particularly when the reasoning behind these proposed amendments is linked to administrative or resource constraints.

It also seems that the Bill is heavily weighted in favour of this last objective at the expense of the first two objectives. I believe that, if implemented, my recommendations in relation to issues raised by the Bill, as summarised below and explained further in the body of the submission, could assist to restore this balance, noting that not all of these recommendations are legislative in nature.

Summary of recommendations

In summary, the recommendations of this submission in relation to the Bill are:

Broadening the purpose of Part 10A (clauses 5 & 7)

- In order to fulfil the policy objectives of the Bill of "emphasising the need for a positive behaviour support approach for all adults with intellectual or cognitive disability and challenging behaviour in funded disability services not just where restrictive practices are required", the Division in which the positive behaviour support plan is located should be re-titled from "Important concepts for using restrictive practices" to "Important concepts for using a positive behaviour support approach".

Your Life Your Choice (clause 6)

- The Department of Communities, Child Safety and Disability Services should provide further information about the safeguards that will be put in place to protect individuals with intellectual disability or cognitive impairment in Queensland if they purchase services from service providers that do not receive any funding directly from the department.

Definition of ‘chemical restraint’ (clause 9)

- The proposal to exclude medication to sedate a person to facilitate a single instance of health care should be excluded from this Bill and subject to further consultation if and when amendments are made to the *Guardianship and Administration Act 2000*.
- If it is decided to pursue this amendment, s123F(2)(b) should be reworded as follows to increase clarity: “using medication, for example a sedative, prescribed by a medical practitioner for the specific purpose of facilitating or enabling the adult to receive a single instance of health care under the *Guardianship and Administration Act 2000*”, and the example should be amended to be consistent with the above.

Providing immunity for service providers to use restrictive practices without consent (clauses 17, 22 & 24)

- In relation to the amendments proposing an extension of immunity to 30 days, rather than extend immunity for 30 days, the relevant short-term decision maker, or the Adult Guardian as guardian for restrictive practice matters, should be enabled by the legislation to provide consent to short-term or interim use of restrictive practices subject to conditions that the further information required is provided within a specified time-frame. If as a result of the further information the decision-maker forms the belief that consent or approval is not warranted, then the legislation should empower the decision-maker to revoke the short-term approval or interim consent. Under this proposal, the decision-maker makes a considered judgement about the appropriateness of the use of restrictive practices and enables immunity for the service provider, while the further information is gathered.
- At minimum, if the immunity provisions are pursued as proposed, I recommend that the provisions relating to containing or secluding an adult before a decision on short-term approval, given effect by clause 17 of the Bill, be excluded given that they effectively constitute deprivation of liberty.
- Furthermore, the obligation for a service provider to provide a statement of rights to the adult and other interested persons should also be mandated in such circumstances, and appropriate support made available to the person to exercise their rights accordingly.

Changing service providers (clauses 26 & 46)

- The Department of Communities, Child Safety and Disability Services should further articulate how continuity of care, safeguards and transparency of process will be achieved in the transfer of clients who are subject to restrictive practices from AS&RS to non-government service providers.

Model Positive Behaviour Support Plan (clause 18)

- The Department of Communities, Child Safety and Disability Services should provide further information about the clinical support that will be provided to the disability services sector to continue to build their capacity in relation to positive behaviour support.

Removal of the requirement to keep and implement a policy on restrictive practices (clauses 29, 12 & 8)

- In removing the legislative requirement to keep and implement a policy, the requirement to regularly review the use of restrictive practices and to provide the results of that review to the relevant decision-maker should be included in the new ‘procedure’ (clause 32).

Requirement to give statement about use of restrictive practices (clause 31)

- The Department of Communities, Child Safety and Disability Services should provide details about how people with disability will be supported to exercise their rights in accordance with the statement.

Reporting on the use of restrictive practices (clause 36)

- The Department of Communities, Child Safety and Disability Services should be required by legislation to report annually on the use of restrictive practices.

Increasing the maximum length of the appointment of the guardian for restrictive practice matters (clause 43)

- The *Disability Services Act 2006* should include an explicit requirement for the service provider to review the use of restrictive practices and to provide the results of that review to the guardian for restrictive practice matters or Queensland Civil and Administrative Tribunal (QCAT).

Queensland Law Reform Commission's recommendations 19-1, 19-2 & 19-3

- The Department of Communities, Child Safety and Disability Services and the Department of Justice and Attorney-General should provide information on how they propose to respond to the Queensland Law Reform Commission's recommendations specifically as they relate to considering the use of restrictive practices outside of funded disability services and the administration of anti-libidinal medication.

Detailed response to the Bill

Broadening the purpose of Part 10A (clauses 5 & 7)

The broadening of Part 10A to encompass all funded service providers that provide services to people with intellectual disability or cognitive impairment (regardless of whether or not they utilise restrictive practices) is welcomed. This goes part way to ensuring that regardless of whether restrictive practices are utilised, a positive behaviour support approach as well as certain principles (as set out in new s123CA) in relation to supporting adults with intellectual disability or cognitive impairment who have behaviour that causes harm to themselves or others, are applied.

Regardless of these amendments, the way in which the positive behaviour support plan is presented within the legislation is still inextricably linked to the actual use of restrictive practices. This is an issue that many stakeholders have raised throughout the review of this regime; that is, the positive behaviour support plan should not be viewed simply as part of compliance with the regime to enable restrictive practices to be used, but for the reason it was originally developed and as intended by the Carter reforms, which is – according to the principles of applied behaviour analysis – as a way to work with a person who exhibits behaviours of harm and their environment to make changes that have the overall aim of reducing or eliminating the difficult behaviour and improving their quality of life.

A positive behaviour support plan should not be seen as something than 'enables' the use of restrictive practices and the legislation should make this clear. The requirements for a positive behaviour support plan continue to be included in Division 2 "Important concepts for using restrictive practices". The title of Division 2 should be changed to "Important concepts for using a positive behaviour support approach", or another similar title to remove the connection between positive behaviour support and the use of restrictive practices.

This would be more consistent with the policy objectives of the Bill as set out in the explanatory notes namely "emphasising the need for a positive behaviour support approach for all adults with intellectual or cognitive disability and challenging behaviour in funded disability services not just where restrictive practices are required".[8]

Recommendation: In order to fulfil the policy objectives of the Bill of "emphasising the need for a positive behaviour support approach for all adults with intellectual or cognitive disability and challenging behaviour in funded disability services not just where restrictive practices are required", the Division in which the positive behaviour support plan is located should be re-titled from "Important concepts for using restrictive practices" to "Important concepts for using a positive behaviour support approach".

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[8] Explanatory Notes, Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2013 (Qld) 2.

Your Life Your Choice (clause 6)

As we progress towards the National Disability Insurance Scheme (NDIS), many states and territories, including Queensland, are focusing on the importance of a person-centred approach to the provision of disability services, including the provision of individualised or self-directed funding.

Queensland launched the 'Your Life Your Choice' Self Directed Support Framework in September 2012. It is a phased approach to self-directed funding. The first stage implements a host provider model under which people with disability are provided with individual allocations of funding that are auspiced through host providers. These host providers work with the person to plan and purchase their support services.

The next phase, now enabled by amendments to the *Disability Services Act 2006* to allow funding to be provided directly to individuals, will allow individuals to directly receive the funding into their own bank accounts and purchase their own services directly. These changes to the way funding is provided and services purchased will not only provide more choice and control for people with disability, and assist Queensland to move towards a NDIS, but will potentially lead to significant changes in the way disability services are funded and delivered.

Increasingly 'block funding' of services will become a thing of the past. New services will enter the market and people will be purchasing their supports from a range of service providers, not just 'disability services' funded by the Department of Communities, Child Safety and Disability Services, or Government more generally.

While these reforms are welcome and integral for a person-centred approach to the provision of disability support, they do pose new challenges for maintaining quality standards and safeguards, particularly in relation to people with intellectual disability or cognitive impairment who are subject to the use of restrictive practices.

In Queensland only 'funded disability services' are regulated by the restrictive practices regulatory regime. Therefore where a person with a disability directly purchases services from a provider that is not funded by the Department at all, the regulatory regime will not apply. This means that not only will the safeguards of this regime not apply to individuals accessing such services, but these services will also not receive the immunity from civil and criminal liability that is provided under the *Disability Services Act 2006* if they use restrictive practices honestly and without negligence in accordance with the legislation.[9]

There is an increasing potential for the unregulated use of restrictive practices under direct funding models both in the current roll-out of self-directed funding in Queensland and under the NDIS. Planning needs to start now in relation to how there will be continuing safeguards, including regulation of the use of restrictive interventions for people with impaired decision-making capacity, particularly those with intellectual disability or cognitive impairment, through the NDIS.

While the amendment proposed by clause 9 will provide clarity in relation to the application of Part 10A *Disability Services Act 2006* to disability services purchased directly by people with self-directed funding arrangements if those services receive any funding from the Department of Communities, Child Safety and Disability Services, they do not address all concerns related to the roll out of the 'Your Life Your Choice' Self Directed Framework.

A continuing concern is those adults who may be in receipt of services from organisations that do not receive any funding from the department. This may occur under the funding arrangements associated with 'Your Life Your Choice' Self Directed Framework if an individual chooses to purchase services directly from a service that does not currently receive any other funds from the department as part of a written agreement. Under those circumstances, neither Part 10A, nor any of the safeguards under the *Disability Services Act 2006*, will apply. This will also be a concern under the impending NDIS, where there will be few, if any, organisations in direct funding arrangements with the department. The Department should clarify how it plans to safeguard adults in either of these arrangements.

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[9] *Disability Services Act 2006* (Qld) s 123ZZB.

Further discussion about the unregulated use of restrictive practices in health facilities (including hospitals and mental health services), family homes and private services is in the section towards the end of this submission in relation to the Queensland Law Reform Commission's recommendations.

Recommendation: The Department of Communities, Child Safety and Disability Services should provide further information about the safeguards that will be put in place to protect individuals with intellectual disability or cognitive impairment in Queensland if they purchase services from service providers that do not receive any funding directly from the department.

Definition of 'chemical restraint' (clause 9)

The proposed amendment in clause 9 of the Bill to exclude medication, used as a sedative, to facilitate a single instance of health care raises a number of concerns.

The exclusion has the potential to change or create uncertainty in relation to the definition of 'health care' under the *Guardianship and Administration Act 2000*. While sedation of an adult with impaired decision-making capacity to facilitate health care is excluded from the definition of 'chemical restraint', it will still require lawful authorisation. There is no common law authority for the treatment of people with impaired decision-making capacity. In Queensland the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998* provide a legislative regime for substitute decision-making, including about health care for adults with impaired decision-making capacity.

There is no specific provision in the *Guardianship and Administration Act 2000* that allows for the sedation of adults to 'facilitate health care'. Therefore it would seem that it is assumed that such sedation would constitute 'health care' which can be consented to by a statutory health attorney, an enduring power or attorney or a guardian. This however is not clear.

'Health care' is defined in schedule 2 to the *Guardianship and Administration Act 2000* as:

5 Health care

(1) ***Health care***, of an adult, is care or treatment of, or a service or a procedure for, the adult—

  (a) to diagnose, maintain, or treat the adult's physical or mental condition; and

  (b) carried out by, or under the direction or supervision of, a health provider.

(2) Health care, of an adult, includes withholding or withdrawal of a life-sustaining measure for the adult if the commencement or continuation of the measure for the adult would be inconsistent with good medical practice.

(3) Health care, of an adult, does not include—

  (a) first aid treatment; or

  (b) a non-intrusive examination made for diagnostic purposes; or

  (c) the administration of a pharmaceutical drug if—

    (i) a prescription is not needed to obtain the drug; and

    (ii) the drug is normally self-administered; and

    (iii) the administration is for a recommended purpose and at a recommended dosage level.

Example of paragraph (b) - a visual examination of an adult's mouth, throat, nasal cavity, eyes or ears.

It may, for example be considered 'health care' if an adult were to be sedated by a dental surgeon or assisting anaesthetist whilst about to receive dental care at a dental surgery or hospital. However, it becomes more doubtful that sedation would constitute 'health care' if the adult is sedated by the service provider because they have difficulty controlling their behaviour sufficiently to get them into a car to take them to the dentist or the doctor. The latter interpretation of the breadth of the exclusion in new subsection 123F(2)(b) is given credence by the example of when this subsection applies "sedating an adult before attending a dentist appointment is not chemical restraint".

This example, however, seems exactly what chemical restraint is defined as, that is “the use of medication for the primary purpose of controlling the adult’s behaviour in response to the adult’s behaviour that causes harm to the adult and others”.[10]

It is not clear whether the definition of a ‘single instance’ is intended to cover the use of medication every single instance that a person attends a medical practitioner or dentist. This should be clarified to mitigate against uncertainty for service providers and medical practitioners.

If sedation is to be used every time that a person attends at a medical practitioner or dentist, and if it is applied by the service provider ahead of getting the person to the car, for example, then it would seem that medication is being used to control a person’s behaviour, and may therefore be in accordance with the definition of ‘chemical restraint’.

Given the uncertainty that the proposed provisions may engender, and the fact that this amendment has not been subject to consultation, particularly with stakeholders with sufficient interest and expertise in guardianship law and health law, it would respectfully suggest removing it from this Bill and, if necessary, dealing with it in any future amendments to the *Guardianship and Administration Act 2000*.

Recommendation: The proposal to exclude medication to sedate a person to facilitate a single instance of health care should be excluded from this Bill and subject to further consultation if and when amendments are made to the *Guardianship and Administration Act 2000*.

If it is decided to pursue this amendment, s123F(2)(b) should be reworded as follows to increase clarity: “using medication, for example a sedative, prescribed by a medical practitioner **for the specific purpose of facilitating or enabling** the adult to receive a single instance of health care under the *Guardianship and Administration Act 2000*”, and the example should be amended to be consistent with the above.

Providing immunity for service providers to use restrictive practices without consent (clauses 17, 22 & 24)

There are a suite of amendments in this Bill that have the overall effect of providing immunity from civil and criminal liability for service providers to use restrictive practices without consent in certain circumstances. The Explanatory Notes state that these amendments are in response to concerns raised by service providers about delays in obtaining approvals and consents to use restrictive practices.

Currently service providers only receive immunity from civil or criminal liability if they use restrictive practices in accordance with a relevant approval or consent, and in accordance with any relevant positive behaviour support plan, to the extent that they act honestly and without negligence.[11]

It seems that some service providers have raised two key concerns in relation to the short-term approval process. First is the duplication that can occur between the information that is needed in the application and the short term plan that must be provided within 14 days of an approval. In response this Bill proposes to remove the requirements for a short-term plan and only an application will need to be submitted. This seems a reasonable response to avoid unnecessary duplication.

The second concern that has been raised is the length of time it has taken the Adult Guardian’s office or the Chief Executive to consider the application and provide consent or otherwise. In response this Bill seeks to address service providers’ concerns by allowing them to contain or seclude an adult or use other restrictive practices with immunity from civil or criminal liability for up to 30 days while awaiting an approval from the Adult’s Guardian’s office or the Chief Executive.

While there are a number of specific concerns in relation to both proposals which are outlined below, collectively these amendments seem to extend immunity to service providers to use restrictive practices without consent for reasons of administrative convenience and resource constraints.

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[10] *Disability Services Act 2006* (Qld) s123F (as it will be amended by the Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2013 (Qld), cl 9).

[11] *Disability Services Act 2006* (Qld) ss 123ZZB, 123ZZC.

This is concerning given that the legislative framework has now been in place for five years and, as discussed in the introductory section, while service providers were originally provided with transitional periods (in which immunity was provided to use restrictive practices while they aimed for full compliance with the legislation) the requirement for full compliance has now been in place since 1 April 2011. Arguably, the amendments will result in a backwards step should these standards once again be relaxed.

As an example, the proposed amendments would allow for a service provider to contact the Chief Executive to request a short-term approval for the use of prone restraint, a physical restraint technique with known risks including death. Assume for a moment that the Chief Executive's delegate is snowed under with work and is therefore unable to consider the request in a timely manner. Under the proposed provisions, the service provider can continue using this dangerous technique for up to 30 days without anyone having objectively considered the appropriateness of this and/or the potential risks to the adult.

If, as the Explanatory Notes suggest, the key reason immunity is proposed to be provided, is to enable time for further information to be provided to justify the use of a restrictive practice or for further professional advice on the adult's needs, it would seem that a better approach would be for the relevant decision-maker to be empowered to provide a short-term approval or interim consent subject to conditions that the further information is provided by the service provider. If as a result of the further information the decision-maker forms the belief that consent or approval is not warranted, then the legislation should empower the decision-maker to revoke the short-term approval or interim consent.

Under this proposal, the decision-maker makes a considered judgement about the appropriateness of the use of restrictive practices and enables immunity for the service provider while the further information is gathered. Furthermore, the obligation for a service provider to provide a statement of rights to the adult and other interested persons should also be mandated in such circumstances, and appropriate support made available to the person to exercise their rights accordingly.

There are two broad circumstances where immunity is proposed to be extended:

Seeking a short term approval to use restrictive practices

Containing or secluding an adult before a decision on short-term approval (clause 17)

This amendment allows a service provider to contain or seclude an adult in circumstances where the relevant service provider has asked in writing for a short-term approval of the restrictive practice from the Adult Guardian under Chapter 5B, Part 4 of the *Guardianship and Administration Act 2000* and the approval has not been decided. The service provider can use the restrictive practice until the Adult Guardian provides notice to the service provider about the decision whether to give the short-term approval or for up to 30 days, whichever comes sooner.

The new section 123OA states that the service provider only has immunity if "a positive behaviour support plan or a respite/community access plan for the adult is being implemented".[12] It is unclear whether this means that an existing consent or approval is in place for another type of restrictive practice, or whether the service provider may, of their own accord, have developed and be implementing a positive behaviour support plan.

This latter interpretation is given credence by the new section 123CA (inserted by clause 7) that states that positive behaviour support planning must now be utilised by any funded service provider who provides support to any adult with an intellectual disability or cognitive impairment who has behaviour that causes harm to the adult or others, regardless of whether restrictive practices are used or not. In the latter circumstance, it is presumed that the service provider will not be required to seek an approval or consent in relation to implementation of the plan given that it does not involve the use of restrictive practices.

Further, given the severity of the impact on a person's liberty imposed by the use of containment (which means detaining a person against their will in an environment from which they are unable to leave without

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[12] Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2013 (Qld) cl 17, new section 123OA(1)(c).

support) and seclusion (which means detaining a person in a room on their own), allowing the use of such practices without consent with immunity from civil or criminal liability is troubling. Usually in our society a person can only be deprived of their liberty if they have been found by a court to have committed a crime (or have been accused of a crime and are on remand), or they are subject to another type of involuntary treatment order (such as for mental illness).

Providing power to disability service providers to detain a person against their will without a court order, or at least consideration by an independent entity, is, arguably, not commensurate with our community's current standards of law and justice, fundamental legislative principles, nor Australia's human rights obligations.

Using chemical, mechanical or physical restraint, or restricting access, before decision on short-term approval (clause 24)

This amendment is a complementary amendment to clause 17 that responds to delays in obtaining the Adult Guardian's consent to short-term use of restrictive practices for containment and seclusion. In the case of clause 24, the amendment responds to delays in receiving the Chief Executive's consent to the short-term use of restrictive practices other than containment or seclusion.

This clause allows service providers to use restrictive practices (other than containment or seclusion) with immunity from civil or criminal liability for up to 30 days while awaiting approval from the Chief Executive.

Like clause 17, this clause also inserts a requirement that "a positive behaviour support plan or a respite/ community access plan for the adult is being implemented".[13] Similar uncertainty arises about whether this refers to a positive behaviour support plan that has been developed in accordance with the new section 123CA, inserted by clause 7, or whether it is one that has been developed when previously seeking consent or approval for another type of restrictive practice.

Seeking a new consent from the Adult Guardian

Using chemical, mechanical or physical restraint, or restricting access, if consent ended (clause 22)

This particular amendment responds to concerns from service providers about delays in obtaining consent from the Office of the Adult Guardian, where the Adult Guardian is appointed as guardian for restrictive practice matters. In particular it occurs when the Adult Guardian has previously provided consent to use a restrictive practice (other than containment or seclusion) and the consent has expired, but a new consent has not yet been provided.

The new section 123ZCA will allow the service provider to continue to use the restrictive practice with immunity for up to 30 days after the original consent ends while awaiting a decision from the Adult Guardian's office.

Recommendation: In relation to all the amendments proposing an extension of immunity to 30 days, rather than extend immunity for 30 days, the relevant short-term decision maker, or the Adult Guardian as guardian for restrictive practice matters, should be enabled by the legislation to provide consent to short-term or interim use of restrictive practices subject to conditions that the further information required is provided.

If as a result of the further information the decision-maker forms the belief that consent or approval is not warranted, then the legislation should empower the decision-maker to revoke the short-term approval or interim consent. Under this proposal, the decision-maker makes a considered judgement about the appropriateness of the use of restrictive practices and enables immunity for the service provider, while the further information is gathered.

At minimum, if the immunity provisions are pursued, I would recommend that the provisions relating to containing or secluding an adult before a decision on short-term approval (given effect by clause 17 of the Bill) be excluded given that they effectively constitute deprivation of liberty.

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[13] Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2013 (Qld) cl 24, new section 123ZDA(1)(c).

Furthermore, the obligation for a service provider to provide a statement of rights to the adult and other interested persons should also be mandated in such circumstances, and appropriate support made available to the person to exercise their rights accordingly.

Changing service providers (clauses 26 & 46)

The effect of the amendments

These amendments will assist service providers where a client already in receipt of restrictive practices transfers from one service provider to another.

Currently where a guardian for restrictive practice matters is appointed for an adult and the adult changes to a new service provider, then the new service provider must undertake an assessment and prepare a new positive behaviour support plan for the person, in preparation for seeking the guardian's consent to use restrictive practices or QCAT's approval to use containment or seclusion. This is because the new environment in which the adult is in receipt of services as well as the new staff will have potential implications in respect of its impact on the person and this will therefore necessitate a new assessment and potentially a revised plan.

Under the proposed amendments, while a new assessment and plan is prepared, clause 26 clarifies that the service provider can apply for a short-term approval from the Chief Executive.

Clause 46 clarifies that where a client is subject to containment or seclusion (an approval that would usually expire when a client changes service providers), the service provider can seek a short-term approval from the Adult Guardian prior to the expiry of the approval. It also provides that a service provider can apply for a short-term approval for containment and seclusion from the Adult Guardian where there is an existing guardian for restrictive practices (respite).

The amendments combined with the extension of immunity for service providers

While these amendments will provide clarity for service providers and will maintain some level of safeguards for clients (by requiring a new decision to be made within the context and environment of the new service provider), combined with the effect of clauses 24 and 17 there are also potential risks.

Clause 17 allows service providers to use containment and seclusion with immunity from civil or criminal liability for up to 30 days while the service provider awaits a short-term approval from the Adult Guardian. Similarly clause 24 allows a service provider to use restrictive practices (other than containment or seclusion) with immunity from civil or criminal liability for up to 30 days while the service provider awaits a decision from the Chief Executive in relation to a short-term approval.

The concerns raised previously about the amendments made by clauses 17 and 24 are compounded in this situation where, not only will a service provider potentially be utilising restrictive practices, including containment and seclusion with immunity and without an effective consent, but such practices will be used in a new service, with new staff and a new environment that the previous decision-maker has not had the opportunity to review.

As discussed above in relation to clauses 24 and 17, the uncertainty in relation to what 'positive behaviour support plan' needs to be implemented to gain immunity under these new sections potentially means that a new service provider could qualify for the 30 day immunity by implementing the existing positive behaviour support plan for the person (from the previous service provider) or one that they have developed themselves in accordance with the new section 123CA inserted by clause 7.

Without due consideration for clinical efficacy and inadvertent risks of harm associated with the application of the proposed restrictive practices in the new environment, this has the potential to place the person at significant risk. It also presumes that the person lacks decision-making capacity, which is inconsistent with the basic premise underpinning the *Guardianship and Administration Act 2000*.[14]

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[14] *Guardianship and Administration Act 2000* (Qld) s 7.

Transitioning AS&RS clients to the non-government sector

The Queensland Government has accepted the Commission of Audit's recommendation (number 98) to "transition all services currently provided by the Accommodation Support and Respite Services to the non-government sector through a formal and transparent re-commissioning process that allows for a progressive movement towards client choice and control."[15]

The amendments proposed to be made by clauses 26 and 46 will make it easier to transition a client who is subject to restrictive practices from one service provider to another. While this amendment will reduce 'red tape' for service providers more generally, it will also arguably make it easier to transition the clients in the government's Accommodation Support and Respite Services (AS&RS) to the non-government sector, with potential risks arising if due attention is not given to continuity of care in accordance with individual needs.

The Commission of Audit Report stated that over 1000 clients are in receipt of services from AS&RS,[16] with many of these people having high and complex needs including behavioural support needs.[17] It is therefore likely that many may be subject to restrictive practices. It is crucial that the transition of these clients to the non-government sector is undertaken, as stated by the Commission of Audit, with careful consideration of continuity of care at a commensurate level for all transferred clients.[18]

There is a concern that the combined effects of the amendments proposed by clauses 26, 17 and 24 may diminish safeguards for clients, specifically those clients with high and complex needs subject to restrictive practices who are part of the 'recommissioning' of the AS&RS services. It would be important to hear from the Department of Communities, Child Safety and Disability Services how continuity of care, safeguards and transparency of process will be achieved for AS&RS clients.

Recommendation: The Department of Communities, Child Safety and Disability Services should further articulate how continuity of care, safeguards and transparency of process will be achieved in the transfer of clients who are subject to restrictive practices from AS&RS to non-government service providers.

Model Positive Behaviour Support Plan (clause 18)

The development of a model or 'exemplar' Positive Behaviour Support Plan is a welcome addition that will assist with the development of the sector's capability in providing appropriate support for people with intellectual disability or cognitive impairment who exhibit behaviours that may harm themselves or others.

Capability and capacity of the sector – positive behaviour support

The Carter Report was adamant in its assertion that any legislative framework for the use of restrictive practices should prohibit the use of restrictive practices unless they are independently approved as part of an individualised positive behaviour support plan consequential upon a comprehensive assessment of the individual and his/her needs.[19] The aim of the positive behaviour support plan being to outline strategies to meet the adult's needs, improve the adult's capabilities and quality of life, and reduce or eliminate 'challenging' behaviours and the need for restrictive practices.

Anecdotally it seems that the Positive Futures reforms have brought about positive changes in the way care and support is provided to adults with intellectual disability or cognitive impairment who exhibit 'challenging' behaviours, and that there is now a greater understanding of positive behaviour support and its benefits for supporting people with disability. Unfortunately, however there is little evidence to rely upon to objectively assess the sector's capability in this regard.

The exception is the recent clinical audit and practice review of positive behaviour support plans conducted by Dr Liz Kiata-Holland, Fiona Davis, Simon Wardale and Professor Karen Nankervis at the Centre of Excellence for Behaviour Support, which indicates that positive behaviour support plans in Queensland are overly focused on compliance with the legislative framework and not meeting basic standards when it

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[15] Queensland Commission of Audit, *Queensland Commission of Audit Final Report* (February 2013) , tabled in Parliament 30 April 2013, 3-188.

[16] Ibid, 3-185.

[17] Ibid, 3-186.

[18] Ibid, 3-187.

[19] W Carter, above n 3.

comes to those aspects of the plan that focus on applied behaviour analysis.[20] Having said that, the limitations inherent in the plans reviewed would suggest that despite many of them being 'approved', they may still not be fully legislatively compliant.

More specifically, the plans do not adequately identify why the 'challenging' behaviours are occurring or identify replacement behaviours that can be taught and strategies for teaching them; core strategies of the positive behaviour support approach. The research indicated that of the 139 plans audited against the *Behaviour Support Plan Quality Evaluation scoring guide version II* (BSPQEII), the mean score was 6.53. Given that a score of 12 or under indicates that a plan is not of acceptable quality and should be rewritten, the results indicate a very poor quality of plans for this study.

These results are very concerning given that Queensland has been implementing these reforms for 5 years and a very significant investment in building the capability of the sector to implement positive behaviour support. Legislation alone will not change practice nor build capability. It is important that there is:

- An ongoing and targeted investment in developing the sector's capacity to implement a positive behaviour support approach;
- Effective clinical leadership and oversight for assessment, planning, implementation and review;
- Appropriate data collection and research to determine the effectiveness of these initiatives;
- Monitoring of the use of restrictive practices in Queensland; and
- Support for people subject to restrictive practices to make choices and exercise their rights.

Clinical leadership and oversight

The importance of clinical oversight by experienced and qualified clinicians, particularly with respect to the preparation and implementation of positive behaviour support plans, is crucial to the regime. It is not the primary responsibility of decision-makers, such as guardians for restrictive practice matters or QCAT, to assess the clinical efficacy of a positive behaviour support plan or its implementation, nor do they have expertise in this regard. Rather decision-makers must be provided with advice and evidence regarding the efficacy of these plans.

The significant investment in clinical resources made by the Department as part of the Positive Futures reforms should be made available to both build the capability of the sector and provide expert advice to decision-makers about the efficacy of the positive behaviour support plans that are presented with an application for approval/consent to use restrictive practices. Other types of support for decision-makers may include guidelines for example about what an effective plan should include.

Furthermore, these clinical resources should be applied in such a way as to build capability at all levels of service provision by working 'with' and not 'for' service providers and, in doing so, to provide further education and training at the coal-face.

Without this ongoing investment in building the sector's capability, and evidence-based assessment and monitoring of the efficacy of the current approaches to working with adults with intellectual disability or cognitive impairment, the new 'model behaviour support plan' will only go part way to addressing the deficiencies identified by the audit conducted by the Centre of Excellence for Behaviour Support.

Recommendation: The Department of Communities, Child Safety and Disability Services should provide further information about the clinical support that will be provided to the disability services sector to continue to build their capability in relation to positive behaviour support.

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[20] L Kiata-Holland, F Davis, S Wardale and K Nankervis, 'A Clinical Audit and Practice Review of Positive Behaviour Support Plans in Queensland' (2013) Unpublished Research, Centre of Excellence for Behaviour Support.

Removal of the requirement to keep and implement a policy on restrictive practices (clauses 29, 12 & 8)

Removal of the legislative requirement to keep and implement a policy on restrictive practices and instead relying on the Human Services Quality Framework is concerning. It is assumed this amendment is designed to achieve a ‘regulatory reduction’. However, given that the explanatory notes state that services will continue to be required to keep and implement a policy on restrictive practices, there seems little ‘advantage’ or reduction in ‘red-tape’ for the actual service provider. What the effect of the removal of the obligation does do however, is both down-play the significance of the issue and remove important legislative requirements.

Division 6 not only sets out an important obligation to keep and implement a policy in relation to restrictive practices, it also played an important legislative role in relation to the requirement for the regular review of the use of restrictive practices by service providers. The current section 123ZV (in Division 6) contains the legislative requirements for the department’s policy on the use of restrictive practices which must currently be reflected in the service provider’s policy on the use of restrictive practices. Subsection (2)(a)(ii) requires the service provider to review the use of restrictive practices at least once during the guardian’s appointment or if it is an informal decision maker, every 12 months. This legislative requirement will be repealed by clause 29.

The only other place in which the legislative obligation to review the use of restrictive practices by a service provider is mentioned is in the new section 123L inserted by clause 13, which sets out the requirements for a positive behaviour support plan. The plan must include information about the intervals at which a service provider must review the use of restrictive practices which is: (a) for a restrictive practice other than containment and seclusion at least once during each 12 month period; (b) for containment and seclusion, when required by the chief executive or at least once during the period of approval. However, this is arguably less of a legislative imperative to review the use of restrictive practices, rather an obligation to include the information about the regularity of the review in the positive behaviour support plan.

Further, there is nothing in the legislation that currently requires the service provider to provide the results of this review to the relevant decision-maker (that is, the guardian for restrictive practice matters or QCAT).

Requirement to keep and implement a procedure (clause 32)

While the Bill removes the requirement to keep and implement a policy on restrictive practices, the Bill also inserts a new requirement to keep and implement a procedure. The procedure, which must ensure that an individual acting for the relevant service provider has sufficient knowledge and expertise in relation to the lawful and appropriate use of restrictive practices, is currently part of the existing policy in Division 6 of Part 10A that is being omitted by clause 29.

It is unclear, however, why it is proposed to call this new requirement a ‘procedure’ given that a procedure is usually operational in character, ‘a series of actions conducted in a certain order or manner’,[21] whereas a policy provides overall direction or guidance for ‘a course or principle of action adopted or proposed by an organization or individual’.[22] Given the proposed requirements and the definitions associated with a policy versus a procedure, it would seem that the proposed requirement is more policy-related in nature.

Recommendation: In removing the legislative requirement to keep and implement a policy, the requirement to regularly review the use of restrictive practices and to provide the results of that review to the relevant decision-maker should be included in the new ‘procedure’ (clause 32).

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[21] *Oxford Dictionary* (2013) Oxford Dictionaries Online <http://www.oxforddictionaries.com/definition/english/procedure>.

[22] *Oxford Dictionary* (2013) Oxford Dictionaries Online <www.oxforddictionaries.com/definition/english/policy?q=policy>.

Requirement to give statement about use of restrictive practices (clause 31)

The requirement to give a statement to an adult upon whom the service provider is considering the use of restrictive practices is a welcome inclusion. However its efficacy in safeguarding clients will be affected by a number of issues.

In addition to regular reviews, there is a right for a person subject to restrictive practices to seek a review of containment and seclusion or the appointment of a guardian for restrictive practice matters at any time. While this is an important right, to be an effective right, people with disability need support to exercise it.

People with disability who are subject to restrictive interventions are often highly vulnerable, have limited communication abilities and there is a significant potential for their human rights to be violated and for abuse to occur.

A client can only be subject to restrictive practices if they have impaired capacity for restrictive practice matters. This means that the client's ability to understand the nature of the statement and the avenues for review and redress may be limited. While the new section 123ZZCA requires the statement to be explained in way that has appropriate regard to the adult's disability, the information being imparted is potentially quite complex (such as how to apply to QCAT for the review of an appointment of a guardian for restrictive practice matters). While the statement must also be given to an 'interested person' there is no guarantee that the 'interested person' will be a person who is sufficiently independent of the service provider.

Strategies, resources and tools must also be developed to assist people with intellectual disability or cognitive impairment to exercise choice and control, make decisions about whether they are getting good outcomes from the services and supports they purchase, and protect themselves from abuse, neglect and exploitation.

This approach should be part of a range of strategies aimed at the prevention of abuse, neglect and exploitation of people with disability, and should be combined with access to independent individual advocacy.

Unfortunately in the five years since the implementation of the reforms associated with the Carter Report, there have been few initiatives aimed at supporting people with intellectual disability or cognitive impairment subject to restrictive practices to exercise their rights under this regime. This legislative amendment of itself will not assist people with disability to exercise their rights.

Recommendation: The Department of Communities, Child Safety and Disability Services should provide details about how people with disability will be supported to exercise their rights in accordance with the statement.

Reporting on the use of restrictive practices (clause 36)

The new requirement for service providers to report on the use of restrictive practices is long overdue. The lack of available data on the use of restrictive practices in Queensland is unacceptable. Given that there is no data to show the effectiveness or otherwise of these strategies to reduce the use of restrictive practices, it is therefore not possible after five years of investment in legislative, educative, clinical and other resources to say with any certainty which, if any, of these initiatives have worked.

Monitoring the use of restrictive practices is the only way to measure whether strategies for reducing and eliminating the use of restrictive practices are working, and arguably the only way to really reduce and eliminate restrictive practices.

For these reasons, monitoring and data collection must start as soon as possible. This monitoring should be multi-faceted and focus not just on legislative compliance but also on improvements in service provider understanding and capability, as well as on outcomes for the adults.

While data will be made available to the statutory agencies such as QCAT, the Adult Guardian, the Public Advocate as well as the relevant service provider, in the interests of openness and transparency, publically available reports should also be produced, for example through the annual reporting process.

Since the commencement of the restrictive practices legislative scheme in Victoria, the Senior Practitioner has reported annually on the use of restrictive practices. These annual reports provide a valuable source of comprehensive information on the use of practices such as restraint and seclusion in relation to vulnerable people with disability in Victoria, including the demographic profile of people who are subject to restrictive practices, the rate of use of restrictive practices and the nature of the use of restrictive practices (for example, the types of restraints that are used).

Recommendation: The Department of Communities, Child Safety and Disability Services should be required by legislation to report annually on the use of restrictive practices.

Increasing the maximum length of the appointment of the guardian for restrictive practice matters (clause 43)

Allowing QCAT to appoint a guardian for restrictive practice matters for up to two years (currently the maximum appointment time is one year) will give QCAT increased flexibility. Importantly QCAT will continue to retain the flexibility to provide for shorter appointments depending on the circumstances of the case.

It is important however to distinguish reviews of the guardian’s consent to use a particular restrictive practice from the issue of the maximum length for the appointment of a guardian for restrictive practice matters. It is important that restrictive practices cannot be used indefinitely (for up to two years) and a maximum length of time for consent is a crucial safeguard in that respect.

The primary purpose of a review is to assess how well the positive behaviour support plan is being implemented, whether there have been improvements in the adult’s circumstances and to determine whether there is an ongoing need for the use of restrictive practices. At the time of the review it is be important for the decision-maker to see evidence of how the positive behaviour support plan has been implemented and the progress that has been made towards reducing and eliminating the use of restrictive practices.

The current section 123ZV contains requirements for the department’s policy on the use of restrictive practices; currently the legislation ensures that these are reflected in the service provider’s policy on the use of restrictive practices. Subsection (2)(a)(ii) requires the service provider to review the use of restrictive practices at least once during the guardian’s appointment or if it is an informal decision maker, every 12 months. This legislative requirement will be repealed by clause 29 (but the explanatory notes state it will be retained in policy).

Clause 13 inserts new section 123L which sets out the requirements for a positive behaviour support plan, including that it include information about the intervals at which a service provider must review the use of restrictive practices which is: (a) for a restrictive practice other than containment and seclusion at least once during each 12 month period; (b) for containment and seclusion, when required by the chief executive or at least once during the period of approval. Arguably however, as discussed above, this is less of a legislative obligation to conduct a review, but more of an obligation to include information on the regularity of the reviews in the positive behaviour support plan.

There is also nothing in the legislation that requires the service provider to provide the results of this review to the relevant decision-maker (that is the guardian for restrictive practice matters or QCAT). This is an important safeguard, particularly given the extension of the appointment of guardians for restrictive practice matters from twelve months to 2 years and would be a legislative prompt for a review of the use of the practice by the guardian.

Recommendation: The *Disability Services Act 2006* should include an explicit requirement for the service provider to review the use of restrictive practices and to provide the results of that review to the guardian for restrictive practice matters or QCAT.

Determining impaired capacity for restrictive practice matters (clause 26)

The insertion of the new subsection s123ZK(2)(aa) to ensure that an adult's capacity for restrictive practices is considered by the Chief Executive is strongly supported. Given the presumption at common law, reflected in the *Guardianship and Administration Act 2000*, of capacity for all adults, this determination of capacity is important.

To appoint a guardian for restrictive practice matters or approve the use of containment and seclusion, QCAT must be satisfied that an adult has impaired capacity for making decisions about the use of restrictive practices.[23] Each time a new approval for containment and seclusion is provided (after 12 months) or a guardian for restrictive practice matters is re-appointed (currently after 12 months), the adult's capacity for restrictive practice matters must again be assessed.

Prior to this amendment, the assessment of capacity occurred quite late in the process for adults subject to restrictive practices. Usually a short-term approval may have been made and an assessment undertaken and the plan developed, prior to the application to QCAT (for containment and seclusion or the appointment of a guardian for restrictive practice matters).

Proper consideration must always be given to the issue of capacity and it is also important that ongoing assessment of the adult's capacity occurs.

Queensland Law Reform Commission

In its final report, *A Review of Queensland's Guardianship Laws*,[24] the Queensland Law Reform Commission (QLRC) focused specifically on restrictive practices in chapter 19 of the Report. The QLRC made a number of recommendations (recommendations 19-1, 19-2 and 19-3) about what should be considered when the restrictive practices legislative framework is reviewed by the Queensland Government including the use of restrictive practices outside of funded disability services and the administration of anti-libidinal medication.

The review of the legislative framework for restrictive practices in the *Disability Services Act 2006* and the *Guardianship and Administration Act 2000* as represented in the Discussion Paper and this Bill, did not consider either of these issues.

Restrictive practices used outside of funded disability services

The current regulatory regime for restrictive practices in Queensland only extends to disability services provided or funded by the Queensland Government's Department of Communities, Child Safety and Disability Services, which limits the extent of its protections given that many people with impaired decision-making capacity are supported through other systems in Queensland, such as hospitals, mental health services, aged care facilities, boarding houses and other health facilities.

There are a significant number of people with intellectual disability or cognitive impairment residing in long-stay health care facilities in Queensland. In 2013, the Office of the Public Advocate commenced a research and advocacy project aimed at promoting the rights and interests of people with intellectual disability or cognitive impairment residing in psychiatric hospitals, hospitals, rehabilitation services and other health care facilities. As at May 2013, Queensland Health reported that there were 271 people with intellectual disability or cognitive impairment continuing to reside in long-stay health facilities in Queensland.

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[23] *Guardianship and Administration Act 2000* (Qld) ss 80V(2)(a), 80ZD(1)(a).

[24] Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Report No 67 (2010).

Two broad groups of people remaining in long-stay health care facilities were identified:

- People with intellectual disability who 'missed out' on earlier deinstitutionalisation processes and/or subsequent reforms and have remained living in institutions for as long as 65 years; and
- People with acquired brain injuries residing in hospitals and other health facilities who are being deprived of crucial opportunities for rehabilitation and reintegration back into the community. Some residents have lived in these facilities for as long as 35 years.[25]

The use of restrictive practices such as restraint and seclusion in these facilities (including mental health facilities) is not covered by the restrictive practices regulatory regime in the *Disability Services Act 2006* and the *Guardianship and Administration Act 2000*, nor is it monitored or subject to any type of transparency.

For example, as at May 2013 there were 132 people with intellectual disability or cognitive impairment residing in mental health facilities in Queensland. Of this group, approximately 95 people do not have a mental illness.[26] This means that they cannot be subject to an involuntary treatment order that lawfully authorises involuntary treatment, including detention as well as restraint and seclusion. An involuntary treatment order can only be made for the involuntary treatment of a 'mental illness',[27] and restraint and seclusion can only be applied to 'involuntary patients' under the *Mental Health Act 2000*.[28] The use of restrictive practices such as detention, seclusion and restraint in these facilities is therefore not covered by the legislative framework of either the *Mental Health Act 2000* or the *Disability Services Act 2006*.

In its report, the QLRC focussed on the restriction of the scope of the restrictive practices regime to funded disability services and commented that:

> In the Commission's view, it is highly unsatisfactory that the lawfulness of using a restrictive practice in relation to an adult with an intellectual or cognitive disability, and the requirements for the lawful use of such a practice, depend on whether the restrictive practice is being used by a disability service provider who receives funding from the Department of Communities, by a disability service provider who does not receive such funding, or by an individual acting in a private, as distinct from a commercial, capacity.[29]

The QLRC recommended that:

- Part 10A of the *Disability Services Act 2006* and Chapter 5B of the *Guardianship and Administration Act 2000* should be amended so that the provisions that currently apply to the use of restrictive practices by a funded service provider apply to all service providers of disability services, regardless of the source of their funding.
- Part 10A of the *Disability Services Act 2006 (Qld)* and Chapter 5B of the *Guardianship and Administration Act 2000 (Qld)* should be extended and adapted as necessary, to regulate the use of restrictive practices by individuals acting in a private capacity, such as family members who care for an adult with an intellectual or cognitive disability. This process should be undertaken jointly by the Department of Communities and Department of Justice and Attorney-General.[30]

Anti-libidinal medication

Anti-libidinal medications are commonly used in the management of sex offenders. The most common anti-libidinal medications used are Androcur (cyproterone acetate) and Depoprovera (medroxyprogesterone acetate). They are sometimes collectively described as anti-androgen medication as they act to reduce the levels of male hormones such as testosterone with the aim of reducing sex drive.

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[25] Office of the Public Advocate, *People with Intellectual Disability or Cognitive Impairment Residing Long-Term in Health Facilities: Addressing the Barriers to Deinstitutionalisation* (November 2013), tabled in Parliament 7 November 2013.

[26] Office of the Public Advocate, above n 25, 17.

[27] *Mental Health Act 2000* (Qld) s 108.

[28] *Mental Health Act 2000* (Qld) ch 4A.

[29] Queensland Law Reform Commission, above n 24, 361.

[30] Queensland Law Reform Commission, above n 24, 384, recommendations 19-1, 19-2.

The administration of these medications to people with impaired decision-making capacity in Queensland, including as chemical restraint under the *Disability Services Act 2006* and *the Guardianship and Administration Act 2000*, is highly concerning for the reasons outlined below.

Efficacy

This medication has limited evidence for its efficacy in the treatment of problematic sexual behaviours in sex offenders generally, but particularly for people with intellectual disability.[31] Some research emphasises that while anti-androgens may be effective in reducing physiological arousal, they do not necessarily act on sexual interest or direction. Further, physiological arousal can be peripheral to the motivations of problematic sexual behaviour in sex offenders.

Side-effects

Side-effects, including severe side-effects, are associated with the use of both Androcur and Depo-Provera. With Androcur, the most common anti-libidinal used, side-effects include breast development, weight gain, thrombotic pneumonia, liver toxicity, depression, gallstones, diabetes mellitus and osteoporosis, including increased propensity to broken and fractured bones after long-term use. Depo-Provera, on the other hand, is associated with weight gain, headaches, nausea, lethargy and loss of bone density.

Given the severe side-effects of Androcur in particular, research indicates that the use of Androcur must be carefully managed medically, and monitored for the effects of feminisation, depression, emotional disturbances (every 1-3 months), liver functioning (every month) blood cell count, calcium and phosphate blood levels, blood pressure, and weight (every six months). Bone mineral density must be checked every year in case of increased osteoporosis risk.[32] It is not clear the extent to which this monitoring currently occurs in relation to people with intellectual disability or cognitive impairment who are administered Androcur as a restrictive practice.

Ethical considerations

The use of anti-libidinal medication with sexual offenders, particularly where it is coerced or administered as a condition of release from prison, or in the case of restrictive practices administered involuntarily, has been widely criticised from an ethical standpoint. Apart from the serious side-effects and lack of proven efficacy, the medication has been described as effecting a reversible 'chemical castration',[33] and this decision about whether to take away a person's ability for physiological arousal is associated with many ethical and rights dilemmas.

Consent

One of the key issues for the use of anti-libidinal medication with people with impaired decision-making capacity generally in Queensland is who can and should give consent for the administration of this medication. Of most concern, expressed by the Mental Health Court, QCAT and the QLRC is whether this medication can be administered lawfully to people with impaired decision-making capacity in Queensland. In summary, all parties have thrown serious doubt on whether anti-libidinal medication can be administered as health care in accordance with the *Guardianship and Administration Act 2000*.

In the case of re AAG,[34] the tribunal found that on the evidence before it, the primary purpose for the use of Androcur was the control of AAG's behaviour and was not being used for the proper treatment of a diagnosed mental illness or physical condition. Ultimately the tribunal did not make a determination about the scope of personal matters or health care. The matter was adjourned, and at a subsequent hearing the tribunal appointed the Adult Guardian as AAG's guardian for restrictive practice matters on the basis that the administration of Androcur was a chemical restraint.

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[31] S Hayes et al, 'Anti Libidinal Medication and People with Disabilities - Long Term Follow Up of Outcomes Following Third Party Consent to Medication for Problematic Sexual Behaviour: Report to the Criminological Research Council (2002), 12.

[32] F Thibaut et al, 'The World Federation of Societies of Biological Psychiatry: Guidelines for the Biological Treatment of Paraphilias' (2010) *World Journal of Biological Psychiatry* 11, 604-5.

[33] *Re AAG* [2009] QGAAT 43.

[34] *Re AAG* [2009] QGAAT 43.

Queensland Law Reform Commission

In its report, the QLRC focused specifically on the issue of administration of anti-libidinal medication as part of the chapter on restrictive practices. The QLRC drew attention to the ambiguity in relation to consent to the use of anti-libidinal medication for people with impaired decision-making capacity and specifically whether the use of anti-libidinal medication for the purpose of behavioural control could be consented to by a guardian or whether it constituted chemical restraint under the *Disability Services Act 2006*.

The QLRC recommended that any review of the *Disability Services Act 2006* should consider:

- Whether, and if so how, the restrictive practices legislation should regulate the use of anti-libidinal drugs, including in particular whether:
    - it is appropriate for anti-libidinal drugs to constitute 'chemical restraint' under the restrictive practices legislation or whether their use should require tribunal approval; and
    - there should be any specific requirements for a positive behaviour support plan that is developed for an adult to whom an anti-libidinal drug is administered; or
- Whether anti-libidinal medication, when administered as a form of behavioural control, should constitute a category of 'special health care' under the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld).[35]

In New South Wales, anti-libidinal medication (or treatment that involves the use of androgen-reducing medication for the purpose of behavioural control) is classified as "special medical treatment", and as such only the guardianship tribunal can provide consent for its use in relation to people with impaired decision-making capacity.[36]

The use of anti-libidinal medication as part of the restrictive practices regime does not currently have sufficient safeguards.

Given the complex legal, ethical, clinical and medical efficacy issues associated with its use, there is a strong argument for the suggested approach by the QLRC that anti-libidinal medication should only be administered to people with impaired decision-making capacity as a type of special health care under the *Guardianship and Administration Act 2000*, and thus only able to be consented to by QCAT on the basis of expert clinical advice.

Recommendation: The Department of Communities, Child Safety and Disability Services and the Department of Justice and Attorney-General should provide information on how they propose to respond to the Queensland Law Reform Commission's recommendations specifically as they relate to considering the use of restrictive practices outside of funded disability services and the administration of anti-libidinal medication.

Concluding comments

Thank you for the opportunity to comment on the Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2013.

While I appreciate, and indeed support, the overall intent of the Bill, I remain concerned that some aspects of the Bill appear to be weighted more towards addressing resourcing and administrative issues for service providers and decision-making bodies than on safeguarding the rights and interests of the adults who the legislation purports to protect.

With this in mind, I have offered a number of recommendations for the Committee's consideration; some of these have a legislative basis while others may be achieved through policy or practice responses by the relevant agencies and/or by service providers.

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[35] Queensland Law Reform Commission, above n 24, 385, recommendations 19-3.

[36] *Guardianship Act 1987* (NSW) s 33(1); *Guardianship Regulation 2005* (NSW) cl 9(b).

These recommendations are intended to offer pragmatic alternatives that respond to the issues underpinning the proposed legislative amendments while better upholding the rights of adults with intellectual disability or cognitive impairment who exhibit behaviours that may cause harm.

I would be pleased to lend my support to the Department of Communities, Child Safety and Disability Services in progressing the implementation of the resulting amendments in the interests of ensuring that the rights of people with intellectual disability or cognitive impairment who exhibit ‘challenging’ behaviours are upheld through this process.

I would also be pleased to again make myself available to the Committee, or to the Department, should further clarification be required in relation to any of the points made in this submission.

JMCook.

Jodie Cook
Public Advocate

Office of the Public Advocate

Website	www.publicadvocate.qld.gov.au
Email	public.advocate@justice.qld.gov.au
Write to	**GPO Box 149, BRISBANE QLD 4001**
Telephone	**(07) 3224 7424**
Fax	**(07) 3224 7364**