HEALTH AND COMMUNITY SERVICES COMMITTEE

Members present:

Mr TJ Ruthenberg MP (Chair)
Ms RM Bates MP
Dr AR Douglas MP
Mr JM Krause MP
Mr DE Shuttleworth MP

Staff present:

Ms S Cawcutt (Research Director)
Ms L Sbeghen (Principal Research Officer)

PUBLIC HEARING—DISABILITY SERVICES (RESTRICTIVE PRACTICES) AND OTHER LEGISLATION AMENDMENT BILL 2013

TRANSCRIPT OF PROCEEDINGS

TUESDAY, 17 DECEMBER 2013

Brisbane

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Committee met at 9.32 am

CHAIR: Good morning and welcome. I declare open the Health and Community Services Committee public hearing about the Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2013 open. The hearing is scheduled to finish at 11.40 am. We have a little bit of flexibility on that.

With me today are: Mr Dale Shuttleworth MP, member for Ferny Grove; Ms Ros Bates MP, member for Mudgeeraba; Mr Jon Krause MP, member for Beaudesert, is on the phone and will be here in about 10 minutes; and Dr Alex Douglas MP, member for Gaven. Mr John Hathaway MP, member for Townsville, has sent an apology. He is unable to attend. We are expecting Mrs Jo-Ann Miller MP, deputy chair and member for Bundamba, to be here soon. However, we do have a quorum and it is time, so we are going to commence.

Hansard is making a transcript of the proceedings. The committee intends to publish the transcript of today's proceedings, unless there is good reason not to. The proceedings today are also being broadcast live on the parliament's website. I remind those present that these proceedings are similar to parliament and are subject to the Legislative Assembly's standing rules and orders. Mobile phones should be turned off or switched to silent please.

We will hear today from witnesses from five organisations. I welcome Ms Carol Bunt from the Endeavour Foundation. Ms Bunt, I invite you to make an opening statement. After that, the committee will ask some questions.

BUNT, Ms Carol, General Manager, Client Services, Endeavour Foundation

NAYLOR, Mr Cole, Clinical Social Worker, Endeavour Foundation

Ms Bunt: I would like to thank the committee for inviting the Endeavour Foundation to speak today on the proposed amendments. I am going to provide a broad overview. Obviously we are going to provide further detail in a written submission. The legislation and the amendments we are discussing today provide some critical protections for the people within our services. Importantly, the legislation, as it currently stands, has created an environment of awareness that has increased the identification of restrictive practice and consequently reduced its use. In our organisation the use of RP cases, as we all them, has reduced from over 900 cases in 2006 before the introduction of the legislation to well under 100 currently. Our goal is to reduce that to nil.

I just want to specifically work through the components of the amendments as we see them and provide some commentary on that. Broadly the Endeavour Foundation supports the current amendments and would like to particularly note the following improvements: some improved clarity of the RP definition which we believe better explains some of the practicalities; the inclusion of a focus on positive behaviour support for all service users, not just RP; providing indemnity to organisations for prosecution of up to one month when a plan has not been approved or fallen out of consent; acknowledging the workload for the Office of the Adult Guardian—we think that is a good balance between the two; and introducing a new and welcome requirement to provide a statement about the use of RP to the adult and a person with a sufficient and continuing interest in the adult—we think that is a very positive step—communicating what the restrictive practices are.

We have some questions around some of the amendments. The goal of reducing the prescriptive requirements in plans with the intention of reducing the size of the plans we think is a worthy goal, but we do question necessarily judging a plan on its size. Sometimes a plan is as big as it needs to be according to the needs of the client. So we would like to see a balance between that and less about the size of the plan and how the plan is being implemented. So that is a bit of a theme that I will get to in a moment.

We support the requirement to report because I know we currently report quarterly. But we do question what the impost on our organisation might be with that reporting requirement as we are unclear about what is happening in the regulation around that. So we would be keen on knowing what that involves.

Some of the amendments do not respond to some of the other issues that we see might be either part of the consideration of these amendments or for the future, and that would be that we support the monitoring of the use of RP. However, a further improvement could be that regulators monitor the quality and implementation of plans—so go beyond the use and look more at whether the plans are actually being used with the clients effectively.

CHAIR: Sorry, could you just state that again?

Ms Bunt: So instead of just looking at monitoring the plans, it is about saying how the plans are being used with the clients—so a bit more about the quality and implementation of the plans with clients.

The bill does not actually address concerns around some of the engagement with the medical profession involving RP. At the moment we know that some medical practitioners are sometimes resistant to complete the documentation around RP. As a number of you would be aware, chemical restraint is one of the biggest RP uses. So one of the critical components of that is getting medical practitioners to acknowledge when medication is a chemical restraint. That is one of the things that our organisation is keen to unlock, and how we do that and get medical practitioners to work with services to identify those chemical restraints would be a powerful component. The bill identifies the author of a plan to be an appropriately qualified or experienced person, but a more specific definition about what that person would be would be helpful—so defining that more closely.

That is probably what I am here to say today. I think we do have a question mark around the time frame of getting the submission in in early January—which we intend to meet. But we would like the committee to note that that is a very tight time frame at this time of year. I thank you for your time today.

CHAIR: Thank you, Ms Bunt. Let me start the process. I would like to explore with you a little bit that you support monitoring of RP plans but you would like to monitor the quality of implementation of plans. Could you go into that in a little bit more depth? What do you see that as?

Ms Bunt: I have a practitioner right behind me who is here to give me some advice. So would I be able to ask him for some examples of that?

CHAIR: There is an opportunity, as long as the committee agrees to it, that he could sit with you at the table and answer our questions directly, if that is okay with you?

Ms Bunt: Yes.

CHAIR: Committee, are we okay with that, just with a show of hands? That is fine. Please come to the table. Could you please introduce yourself and give us your qualifications and background?

Mr Naylor: My name is Cole Naylor from the Endeavour Foundation. I am a social worker and I am the author of positive behaviour support plans at the Endeavour Foundation.

CHAIR: Thank you. So my question was around monitoring the implementation of the plans. This is really about you wanting to see a little bit more around that in the legislation.

Mr Naylor: Yes. Endeavour is required to submit plans under a time line; otherwise we have the potential to be fined $50,000 I think it is currently. While we might submit the plans to the Adult Guardian for approval, there is nothing in the legislation about actually getting them implemented by a certain amount of time. So there needs to be some sort of time line or specification in the legislation around that.

CHAIR: So let me take that a little bit further. Are there instances where you would do a restrictive practice plan that may not be implemented? It sits there available so that carers, for example, could use it if they need to?

Mr Naylor: Yes, they could but we always put recommendations, strategies et cetera in. As a practitioner you would train those out, identify the strategies and recommendations. But sometimes there is no requirement that the plan be implemented.

CHAIR: So really what you are talking about is in the event the plan is used that there be some sort of capacity to measure how effective that plan is?

Mr Naylor: Yes. That is probably at the other end as well about clinical governance in regard to how good the plan was, whether the revised plan—the next plan that comes along—is an improvement on the former plan.

CHAIR: Wouldn't the revision of that plan be done as a consequence of developing the new plan? Isn't that part of the process?

Mr Naylor: It is but it is not—it should be, yes. But I do not think it is prescribed anywhere. It is not a requirement anywhere.

Mr SHUTTLEWORTH: So, Mr Naylor, would there be a risk though that if that process was put into place the utilisation of a plan could be extended perhaps? I imagine that the sector's ultimate goal is to reduce the number of restrictions over the course of time. If the plan was there and those measures were being undertaken continually, is there a risk that the utilisation of a plan may actually be extended because people will consider that they need to conform with that more than a continual analysis of the patient with the goal of reducing the types of restrictions? Do you understand what I am asking?

Mr Naylor: No, not really. You will have to rephrase that for me, I am sorry.

Mr SHUTTLEWORTH: If an organisation or a service provider knows that the legislation is in place—if we were to make amendments so that the legislation has these constant measure points in comparison to a plan that has been drafted—they will continue to implement the plan because they know they are being measured against that, as opposed to the ultimate goal of trying to reduce the number of restrictions and reduce the utilisation of the plan.

Ms Bunt: Potentially. So you are actually saying that, if there are tighter restrictions around the implementation of a plan, people hang on to that plan rather than saying, 'We need to do some analysis and move off the plan to a new plan.'

Mr SHUTTLEWORTH: Yes.

Ms Bunt: I hear what you are saying. There is potential for that. What are the checks and balances that help people to move to a new paradigm?

Mr SHUTTLEWORTH: Less restrictive.

Ms Bunt: Yes, to reduce restrictive practice or no restrictive practice.

Mr Naylor: All of the strategies and recommendations in the plan should be heading toward that reduction of restrictive practices anyway. I think it happens naturally. If the staff who are implementing the plan put them into place, it should be reducing their use of restrictive practices.

CHAIR: So that would be part of the monitoring process to see how well that is being conducted?

Mr Naylor: Yes.

CHAIR: I want to follow that up. I feel I am missing something here. I think you are trying to highlight an issue or a concern and I am not sure I am understanding it completely. Maybe it is my ignorance of not having been in a circumstance to have to implement one of these things.

Mr Naylor: As a practitioner we are required to put a positive behaviour support plan together to support an individual so that the restrictive practices are constantly monitored and potentially reduced. There are also quality of life issues that we try to include in a positive behaviour support plan. We are required to put a plan together and review it within a nine-month period, but there is no requirement on the organisation to implement the plan and all of those strategies that we have come up with in the plan. That is the point I am trying to make.

CHAIR: So there is no real monitoring as to whether the plan is implemented or not?

Mr Naylor: That is correct.

CHAIR: And if it is implemented how well it is conducted?

Mr Naylor: That is correct.

CHAIR: From a quality perspective, whether you do a good job or a bad job, you are still going to get paid, in effect?

Mr Naylor: That is correct.

CHAIR: Apart from obvious effects on the person whom the plan is written for, there is no way of really knowing whether the thing is working or not?

Mr Naylor: That is correct.

CHAIR: So there is nothing stopping the implementation of a plan right now. What you are asking for is that prior to the plans being written they are reviewed for the purposes of writing a new plan. So somewhere in the process of implementation you want a mechanism to determine how successful they are.

Mr Naylor: That is right and that they are fully implemented as well.

CHAIR: The plans are written every two years, correct?

Mr Naylor: No, every 12 months. They have to be reviewed every nine months but submitted within a 12-month period.

CHAIR: Again, this is my ignorance and how long is a piece of string, I guess: would you know in a short period of time whether the plan you have written is effective or not?

Mr Naylor: Sometimes. It just depends on the quality of the strategies you have put in the plan.

CHAIR: How in-depth would you see that monitoring? Who would do it? Typically, when you are talking about a quality process you are talking about someone external to the process coming in to have a look at it. Would you envisage a clinician coming in who is not associated with delivering that plan, or would you see someone else doing the monitoring?

Mr Naylor: No, not necessarily. Maybe the clinician is the ideal person, but I guess the strategies for supporting that person—the implementation and recommendations about changing the environment—need to be implemented. Currently that does not happen.

CHAIR: I am sorry to belabour this but I am trying to understand this properly. Unless the organisation itself and its own processes and procedures use an ongoing monitoring process, the reality is that potentially the plan could be approved and the next time it is looked at is when it needs to be reviewed?

Mr Naylor: That is correct.

CHAIR: How often would you see this as a problem? Because sometimes we hear requests like this but when we dive in it is a tiny issue that occurs once in a while. It is not actually an ongoing, real concern. How big an issue is this for you guys?

Mr Naylor: I have worked for three organisations and it is still an issue for all three of them.

CHAIR: So your motivation here really is to ensure that the individual is getting the best possible care?

Mr Naylor: Yes. It is a waste of resources putting quality work into a plan if that plan is not being implemented fully.

CHAIR: Ms Bunt, one of the things you talked about being concerned with was the reporting burden and not understanding what that is.

Ms Bunt: Yes.

CHAIR: Wouldn't this add to that?

Ms Bunt: That is a question, I suppose; whether the reporting burden would delve into the implementation of the plan or not but, yes, you are right. I suppose we are saying that it is a balance.

CHAIR: As a senior executive of an organisation, one of the things I always tried to do was make sure that the reports we were seeking were valuable and useful and were not creating an undue—sometimes you would ask for something and if you did not have the mechanisms in place to properly get that information quickly and easily it could cause an extreme burden on the organisation to find that information. Would you see a monitoring process as burdensome?

Mr Naylor: I think it is beneficial for any organisation to have a clinical governance framework. I think that is what we are moving towards. We do some self-monitoring ourselves—

CHAIR: So you would see it as a natural progression towards a better improvement in what you do and how you do it anyway?

Mr Naylor: Yes.

Ms Bunt: Yes.

CHAIR: I am satisfied, if anyone else wants to ask a question.

Mr SHUTTLEWORTH: Listening to that discussion, am I correct in the assumption that these plans are ultimately devised initially to reduce the level of risk to either the patient or to the service provider because of the patient's actions? If we are reviewing the plans over a shorter period of time, another incident may not have occurred. So you relax the restriction only to again suffer the consequences of not having that in place. Is there a risk that that could occur?

Mr Naylor: It is not actually about the revision of the plan; it is about making sure that the original plan that has been drafted—the strategies, recommendations and changes to the environment et cetera—has been implemented so the behaviours that you are talking about start to

decrease. It is not really about the revision period. As a clinician, I am quite happy that nine months is a relatively good period. It is not really about the revision period; it is about making sure that the strategies—

Mr SHUTTLEWORTH: That the levels of intervention are appropriate.

Mr Naylor:—are being implemented at the coalface.

Dr DOUGLAS: Thank you both for your presentations. I am interested in what you said with regard to the plans themselves and the issue of no defined time line. I am a GP. I have been a GP for 25 years. My understanding is that, if there is no defined time line, the default option is the original plan; is that correct? In other words, if the new plan is put in place but it does not have a definite starting point, if there is a problem the problem defaults to the original plan. Is that correct?

Mr Naylor: We would fall out of consent after 12 months—

Dr DOUGLAS: That is right.

Mr Naylor: We would probably still use strategies within it but as an organisation we would have fallen out of consent so we are then liable for a fine of $50,000. But we would probably use the strategies in the meantime while we are racing around getting another plan.

Dr DOUGLAS: It is an interesting point that you are raising. Is it possible that the deficiency in the legislation is that by not defining a time point it forces the service provider to cobble together parts of what they have got as the new plan and then almost resorting to the original plan until it is defined that the new plan is in place?

Mr Naylor: That could happen, yes.

Dr DOUGLAS: I know this happens in practice. I have seen it many times in many different ways. Because if it is not defined what the agreement is at a point in time then that is not the agreement, is it?

Mr Naylor: No, it will not be.

Dr DOUGLAS: It is not. It is a very good point you have raised. It is in fact a problem that I, too, see with the legislation. By not setting that time it leaves the service providers up in the air, which is essentially what you are raising. With regard to restrictive practices, you alluded to the issue of chemical restraint which I would like to ask you some questions about. I say that because you have said in the preamble of what you have sent to us that a lot of people are under restrictive practices. So there will be issues that will come up because of that. In terms of a time line, have you thought what the time line should be in terms of defining it? Should it be a month or two months? Have you thought about it?

Mr Naylor: The different strategies and recommendations do not necessarily have to be fully put into place, but so long as they are started within a month I think that is quite reasonable.

Dr DOUGLAS: If the guardian could not agree to something within a month or another four weeks after that, what do you think should happen as a result of that? Have you thought about that? Should the plan be rejected or submitted?

Mr Naylor: I think some consultation with the guardian needs to occur because they are the guardian for the particular restrictive practice to see what they want to do in terms of that. It might be that they write to organisations. It might be that they write to the Adult Guardian to say that this plan that has been developed, signed off on and approved is not being implemented.

Dr DOUGLAS: Certain things can occur in this type of practice whereby these things can be difficult to get in. Would there be a mechanism whereby you think you could have an interim agreement which would be reviewed at a certain time? Would that be reasonable in some cases if it was defined?

Mr Naylor: Yes, absolutely.

Dr DOUGLAS: And that maybe should be covered within the act?

Mr Naylor: Yes.

Dr DOUGLAS: Can I get to the issue of chemical restraint? Chemical restraint is widely used in these areas and unfortunately attracts a difficult reputation, for want of a better word. Can you outline some of your concerns that you were raising that need to be defined? Because you say it is lacking within the bill, which I agree. Can you allude to what you thought maybe should be included?

Ms Bunt: I will say something and then I will pass to Cole, who is the practitioner. From our perspective, chemical restraint is not easily defined necessarily unless we have buy in by the medical practitioner, GP or specialist. It can be a fine line between medication and chemical restraint, and we do need it identified by those medical practitioners. At times there is an unwillingness to identify it as chemical restraint. Therefore, if you have not got it identified, how can you then put together a plan to reduce its use? That is broadly it. Is there anything you want to add, Cole?

Mr Naylor: From a practical point of view I have been marched out of doctors surgeries saying I am not prepared to fill in this documentation when I have asked 'Is this medication'—Olanzapine, for example—'for behaviour or is it for an ill health disorder?' There has been a real lack of buy in, I suppose, by doctors to assist us in this process. The other one is about the actual reduction, the titration down, of medications that are identified as restrictive practices, for them to engage in that process.

Dr DOUGLAS: Are you asking for someone? Do you think the bill should have that; that it is lacking?

Mr Naylor: Yes. General practitioners need to have some awareness that they have a legal obligation to enter into this process.

Dr DOUGLAS: Are you saying that they do not currently have that?

Ms Bunt: Not universally.

Mr Naylor: No. Some doctors are great I have to say, but some are not willing to engage with it at all.

Dr DOUGLAS: So is there a better way of doing it? What is lacking in this bill? Doctors have to pay medical defence. You have to conform to all best practice. You have to do all of these different things. There are a lot of guidelines. Just give us a rough idea of what you are saying should be within the legislation.

Mr Naylor: It is more about understanding that they are really valuable in this process. We cannot develop a positive behaviour support plan and we cannot reduce the chemical restraint without their input. If they are not willing to engage in that process, then we are sort of stuck there as well.

Ms Bunt: It is a bit of a mix between, I suppose, the carrot and the stick. Probably some of it is educative—and we take on board that some of that is our responsibility as well. But some of it is saying at what point do we want to say that medical practitioners need to be compelled to respond? I do not know that we have the answer here today.

CHAIR: Dr Douglas, can I just explore that just a fraction, and we are running out of time. Are you saying that a doctor can write a prescription for a medicine and that medicine can be given to the person and that in fact what is happening is that it is a restraint mechanism as opposed to a medication for a condition?

Ms Bunt: Yes.

Mr Naylor: Yes.

CHAIR: So in effect what is happening is that an unapproved restraint practice is occurring.

Mr Naylor: That is correct—well potentially.

CHAIR: Potentially. I am assuming that would occur on the spot. There would be a visitation to a GP or to a medical practitioner who has the authority to write prescriptions. They would see the condition and they would write a prescription. They would make an assessment and write a prescription. I am struggling with this because—

Mr SHUTTLEWORTH: That will not fit into the plan because it would not have been forecast necessarily within that management plan. So how does that—

CHAIR: It is not just that. As Dr Douglas said, doctors have all sorts of guidelines and rules and regulations that they have to follow. They cannot just get a licence and go out and practice. There are all sorts of reasons. I guess I am struggling a little bit to understand. If a doctor makes an assessment for a particular course of action, I am assuming the doctor has good reason for that purpose and I would assume there would be a regular review by the doctor on how the person's—I am sorry; I am being very simplistic. When I go to the doctor and I have a problem and they give me some medicine for it, it is a restricted time frame. I do not get an endless supply of that medicine. The prescription only approves a certain amount. Is that not the case and would the doctor not, on an ongoing basis, have a regular review of that situation?

Mr Naylor: It has been my experience that some doctors will do what they do for you and there is a time frame for your prescription but other medical practitioners just prescribe the medication for years and years and years.

CHAIR: Without significant review of it as a restrictive practice.

Mr Naylor: Yes.

CHAIR: Okay. I understand that now. So what you are really looking for is that if a particular prescription is applied over an extended period of time that actually needs to be assessed as a restrictive practice as opposed to a medical condition.

Mr Naylor: Yes. It needs to be identified that this medication that is being prescribed is a restrictive practice or is it for a medical condition. That is not often forthcoming. The reduction of medication too needs to be—

CHAIR: Considered.

Mr Naylor: It needs to be reviewed.

CHAIR: Okay. Unfortunately we are out of time. I do appreciate your time and we look forward to your submission.

Ms Bunt: Thank you.

Mr Naylor: Thank you.

CHAIR: At this time I welcome representatives from the Queensland Law Society to the table please: Ms Annette Bradfield, President; Ms Karen Williams, member of the Elder Law Committee; and Mr Matt Dunn, Principal Policy Solicitor.

BRADFIELD, Ms Annette, President, Queensland Law Society

DUNN, Mr Matt, Principal Policy Solicitor, Queensland Law Society

WILLIAMS, Ms Karen, Member, Elder Law Committee, Queensland Law Society

CHAIR: Mr Dunn, I think we have seen you here before, haven't we?

Mr Dunn: Yes, Mr Chair. I might be a repeat offender!

CHAIR: Welcome and thank you for giving up your time to both have a look at the legislation and put yourself in a position to make some comments. I invite you to make an opening comment, Ms Bradfield, and if you would then like to hand over to your colleagues.

Ms Bradfield: Thank you very much, Chair, and thank you for the opportunity. At the outset I would just like to state that the Queensland Law Society supports legislation that adheres to fundamental legislative principles and does not support legislation that impedes the rights and liberties of individuals. So the society is generally supportive of the proposed amendments and in particular the spirit of clause 5, which is setting out the purpose of part 10A—and that is to protect rights of adults with an intellectual or cognitive disability, with specific reference to human rights.

Due to the brevity of time to consider the bill, we would like to discuss three key issues: firstly, the importance of external scrutiny and advocacy; secondly, ensuring transparency; and thirdly, ensuring the adult and interested persons are involved in the actual decision making or providing feedback for the adult's positive behaviour plan. For all other issues we would be happy to answer questions on notice, if we may.

CHAIR: Sorry, could you just repeat those three please?

Ms Bradfield: Sure. The first one is the importance of external scrutiny and advocacy; the second one is ensuring transparency; and the third one is ensuring the adult and the interested persons are involved in the decision making or providing feedback on the adult's positive behaviour plan. I will now have Ms Karen Williams, who is a member of the Queensland Law Society Elder Law Committee, look at those issues in a bit more detail.

Ms Williams: Thanks, Annette. As a brief introduction, I am a member of the Law Society Elder Law Committee. I am a barrister with practice in cognitive capacity issues—so guardianship—before QCAT and the Mental Health Review Tribunal. So to explore those three issues more fully I will just take them one at a time. So first is the importance of external scrutiny and advocacy. A fundamental issue is upholding and ensuring the rights and liberties of individuals, which is a cornerstone of our democracy. So, therefore, in our view the use of restrictive practices should have safeguards within so that decisions about the adult are transparent, reviewable and involve independent scrutiny and advocacy. In order to highlight this first issue, I am going to refer you to a case study which is a case called GAS, QCAT matter of 2013. We will have the references in our written submission.

CHAIR: Thank you.

Ms Williams: So this case is a published restrictive practice matter and raises the importance of external scrutiny. It concerned a young man with behavioural issues. Initially the tribunal did not approve an order for containment and seclusion as it was based on a plan that referred to community access that the adult was indeed not receiving. So it was not an actual plan; it was more a theoretical plan, I suppose. So the positive behaviour support plan included community access for a range of difficulties that he was not receiving, and as such QCAT did not consider seclusion, which he was experiencing for 21 hours a day, as being the least restrictive approach available. QCAT were also concerned that the treating doctor's views in relation to clinical concerns were not being regarded in the development of the plan and the approach. So QCAT adjourned the matter. Community access was restored. QCAT approved the plan but also authorised the appointment of a representative to assist in representing the views and wishes of GAS. Importantly, QCAT required that the representative be someone independent of the service provider, who they noted was receiving a substantial package of around $500,000 per annum, and also independent of the funding body.

This case raises the importance of external and independent advocacy in an area that is awash with conflicts of interest. For example, the service provider has an investment in retaining the adult and the package, making it difficult for the adult GAS to move service providers should he have wanted to. It also raises the practical difficulty that when people are spending a long time in

seclusion, as this young man was, it usually means they are living in an extremely austere environment, where furniture is fixed to the floor or to the wall and people do not have the ready access to information via the use of phones or computers et cetera as does the general population.

That is by way of background to our first recommendation. So we suggest amendments to clause 31 in relation to section 123ZZCA, which is the requirement to give a statement about use of restrictive practices. So we are very supportive of the principles that lay behind this clause and commend the requirement to give a statement about the use of restrictive practices for the reasons raised in that earlier case example. In subsection (3) we consider it be a further requirement that the statement expressly state the contact details for independent advocacy for the adult including but not limited to disability advocacy services and/or legal services and the Queensland Law Society. The second recommendation is that there be a review of the individual's plan on a periodic basis, which is an issue that you have previously raised.

The second issue is that of transparency. The Law Society is very supportive of ensuring transparency particularly for persons subject to restrictive practices. To that end, we note that clause 36 in relation to section 123ZZK sets out who the chief executive may give information about the use of restrictive practices. So a recommendation there is for amendments to section 123ZZK to include the adult, the adult support network and the adult's treating doctors and healthcare professionals in the list of persons to be provided information about the use of restrictive practices.

CHAIR: Sorry, could you just repeat that?

Ms Williams: Sure. So it is in relation to section 123ZZK. The recommendation is that there be a specific list of people to be provided information about the use of restrictive practices and that that include the adult, the adult support network, or interested persons I think the legislation refers to, and the adult's treating doctor.

CHAIR: So this is additional to what is mentioned in the bill.

Ms Williams: Yes, in addition to. It just builds in that feedback—

CHAIR: External advocacy.

Ms Williams: Yes. In the interests of portability, ensuring resource efficiency and promoting good practice, we recommend that, similar to forensic orders under the Mental Health Act, we consider that the positive behaviour support plan and the orders attach to the person not to the service provider. There is a marked rigidity in having the plan attached to the service provider, as you can see by the issues raised in GAS and, therefore, a lack of flexibility and portability. The issue is also to align the sector to the incoming NDIS and allow for greater control and choice. So we see this recommendation fitting in there. The recommendation is a clarification of the system to reduce red tape so that the orders attach to the person and not the service provider which burdens the vulnerable adult with unnecessary red tape. Finally, the statement contained in section 123ZZCA refers to a complaints process. We want to alert the committee that generally the complaints process for disability services is an internal process, unlike the complaints process for health services, for example, which is an external process.

Our third issue we are wanting to raise this morning is to ensure the adult and interested persons are involved in decision making and providing feedback for the adult's positive behaviour support plan. We consider that the adult and interested person should be involved and provide input in decision making of the adult's positive behaviour support plan. Our recommendation in relation to this is that the amendments to clause 13, section 123L entitled 'What is a positive behaviour support plan', set out who may provide feedback and suggestions for the plan. We propose that as a minimum the adult, the adult's support network and treating doctors be involved and provide feedback for consideration.

CHAIR: Sorry, that is as part of the development of the plan?

Ms Williams: Yes, but they would be specifically listed. They are the three issues that we wanted to outline. Once again, we welcome questions. However, we will wish to take them away and develop them more fulsomely in our written submissions to be provided later on.

There is one final issue in relation to this consultation that in particular would be helpful for the society and maybe for the committee, and that is if the department could provide a mark-up copy of the amendments so we can see exactly what has gone out and what is replacing it, just by way of a suggestion. That is the extent of our oral submissions.

CHAIR: Thank you. I think you said that the emphasis or the focus of your submission will be on ensuring the liberty and rights of the individual.

Ms Williams: Yes.

CHAIR: Obviously restrictive practices in their very nature are a removal of those rights. A friend of mine has a son who has highly complex disabilities. They have struggled for years. He is now a very powerful young man. They have struggled for years in trying to provide the best possible upbringing they can for him, but he is now subject to some restrictive practices because he can now be quite dangerous when he loses control. That loss of control can be triggered by things that you and I would never ever see as an issue. A dog barking, for example, or a baby crying could be the trigger. You are not advocating that we do not implement restrictive practices; what you are saying is that they are done carefully; is that what you are saying?

Ms Williams: Carefully and lawfully so the letter and the spirit of the law are followed.

CHAIR: And you are comfortable enough that the principles that are stated within the exchanges adequately protect that intent?

Ms Williams: Our recommendations pick up on the thrust of that intent, but our suggestions are carrying it those few steps forward.

CHAIR: So putting an extra layer in that says there is someone external having a look at this. I think that comes back to what we were talking about previously with the other witnesses in regard to monitoring and my comment that typically when you do monitoring someone external to the process would be having a look at that. Maybe that is what we are talking about here: ensuring there is an external set of eyes from someone who is not emotionally involved or involved every day. Familiarity breeds contempt. Sometimes someone who is not there every day and who does not have a particular interest is able to see that, and those people could be GPs.

Ms Williams: That is right. Having that information for the person and for the family included in that statement would be very helpful in those circumstances.

CHAIR: With regard to your recommendation including additional people reviewing plans, what happens—and I myself know of these circumstances—where the family is not interested but we have them listed?

Ms Bradfield: At least they have the opportunity to be involved in the process. It sometimes can lead to difficulties if the family or interested persons are excluded from the decision-making process. If they are interested and they are keen to be involved with the process, then give them that opportunity.

CHAIR: They should be allowed to be involved.

Ms Bradfield: Yes.

Ms Williams: Otherwise it can become a very internal, closed process. The legislation would signal the intention that there be broader consultation by listing the people to be notified and involved.

CHAIR: The other thing I am thinking of is extraordinary circumstances. For example, when we had the flood in Brisbane, one of the things that was reported to me was an extreme workload. Some of the folks were watching TV and were picking up the anxiety in society and so there was a fairly large response to that by some of those folks. What happens in circumstances where the Adult Guardian, for example, is resourced so they can handle the normal workload but the workload increases and the Adult Guardian struggles do that review within the time frames allowed? The legislation has a hard stop on 30 days. Please understand that I think your suggestions are common-sense ones or good ones. I guess my concern is that we make a requirement that is bigger than what we can handle in some circumstances. Would you see that being tied down as tightly as these people must be involved, or would you see it as far as we have to make the opportunity available to them?

Ms Williams: I cannot see that you could legislate that they must be involved. It is a complex issue that we would prefer to take away and mull over and put the answer to that question in our written submissions.

CHAIR: Okay.

Mr SHUTTLEWORTH: Do you think the legislation as it currently exists, or with the proposed additions to those specific clauses, adequately balances the requirements of the individual as well as the service providers? Again, the intent from my understanding is that we are aiming to protect both the person from harming themselves and the person from harming others. Do you think the amendments you propose adequately protect the others?

Ms Williams: In order to protect, there is a stronger role for advocacy for the individual and/or their family or support network. With that stronger role, I think that moves a further way towards protection.

Dr DOUGLAS: You have made very good presentations. My concern really is the issue of inclusiveness, which I think is a good idea in general involving the patient and the wider groups. I can speak with some experience as a doctor in this area. When you are very inclusive there are some people who have not got the patient's interests at heart, and it is more common than people realise. It sometimes leads to legal argument and almost to a point of excluding people from things. It has become very intense with more elderly people with regard to their estates and various people seeking to actively intervene and then pursue an objective. I have had a couple of experiences which were just awful. I am concerned that if you opened that up to what you are probably saying, with this wider and wider involvement, you start drawing in a whole lot of people whose intentions are not always in the interests of the patient. How are you going to control that? It is a real problem. From a doctor's perspective, it is one which is really worrying the medical profession. It is widely discussed and written about.

Ms Bradfield: It is also an issue that is concerning the legal fraternity. While there are a significant number of situations like that which we are aware of, in looking at the population of Queensland and the number of people who are in the ageing population et cetera—I do not have the statistics on hand—I think we always need to be mindful of putting it into perspective with the total number of people who are involved in this scenario. I guess it is more saying they are people to consult with, but it is up to the ultimate decision maker to determine whether or not or how much weight to give concerned members' views or the interested person's views.

Mr Dunn: I think it is fair to say that we are certainly not proposing that these should be only consensus plans and nothing but consensus plans, because quite practically that is never going to be achieved. I think the thrust of our submissions is that a little more transparency is where we need to be and where we need to be moving this towards, and the opportunity for people to have input if they can. Ultimately, there needs to be, as the president said, a final decision maker who makes a ruling or a decision in the best interests of the patient and of the people who may come into contact with the patient.

Ms Williams: As a side issue, QCAT does offer conferencing or a mediation process prior to a hearing. So that is another possible issue that QCAT might want to offer parties.

CHAIR: Unfortunately, our time has expired. Thank you for attending. Thank you for taking the time to have a look at this. We look forward to your submission.

COLLYER, Mr Nick, Systems Advocate, Queensland Advocacy Inc.

MANWARING, Mr David, Solicitor, Queensland Advocacy Inc.

CHAIR: Welcome. Mr Manwaring, I think you were here when the department was here giving its brief?

Mr Manwaring: Yes, that is correct.

CHAIR: Fantastic. I ask you to make an opening statement.

Mr Manwaring: My name is David Manwaring. My interest in these amendments stem from my work as a human rights lawyer with Queensland Advocacy where I provide advice and/or representation to and on behalf of adults who are subject to restrictive practices. QAI is the only organisation in Queensland which provides this type of legal assistance. These submissions reflect the collective view of QAI.

Firstly, QAI would like to commend the Department of Communities, Child Safety and Disability Services for its efforts in producing these amendments. We make particular mention of the following suggested positive changes: including principles for providing disability services in clause 7; introducing model positive behaviour support plans in clause 8, which results in a reduction of prescriptive requirements under clause 13; the statement of rights in clauses 31 and clause 37, which are transitional provisions regarding retrospective giving of statement; the increased emphasis on training under clause 32; and the increased emphasis around data collection and reporting obligations under clause 36. Finally, although there needs to be more work on this clause, we would like to make note of the improved definitions and examples provided in clauses 8, 9, 10 and 11.

We also welcome the proposed suite of measures to enhance safeguards and practices such as policy changes, practice support, increased education and training, as legislation itself seldom produces any change. However, QAI does have concerns that the aim of reducing compliance burdens for service providers has overshadowed any enhancements to rights and safeguards for the adults. The result is a somewhat permissive attitude towards the use of restrictive practices—notably in the immunity provisions. As already alluded to, our main concern with the amendments is the immunity provisions, and I will focus on this mostly today—and all our concerns arise from our practice experience in this area. We will make a more complete written submission in due course.

The immunity provisions can be found in clauses 17, 22 and 24. The notion of 'immunity' for the use of restrictive practices on a vulnerable person directly opposes the beliefs and values of QAI. Whilst we acknowledge that there may be times when the use is required to keep the person or others safe, it should always be the least restrictive and the last resort option. The proposed immunity appears only to be required to counter current administrative and resourcing burden and is not a measure which will improve the quality of life for the person or to protect their rights.

Practice is invariably different to legislative intent. Therefore, we have concerns about how the proposed immunity provisions will be interpreted by service providers. It is obvious that the current regime fosters genuine concerns about the lawful use of restrictive practices, thereby providing some protection in ensuring practice matches legislation. We are concerned that the proposed immunity provisions will lead to a more permissive approach in using restrictive practices and see this protection lost somewhat.

Currently service providers and individuals have immunity under section 123ZZB and section 123ZZC of the Disability Services Act providing they act honestly and without negligence in using restrictive practices. There are two common law doctrines which provide a similar protection when using restrictive practices without authorisation if the need arises. The first is the 'duty of care' of service providers to provide a safe working environment and to keep the adult from harm. Workplace health and safety legislation reinforces to some extent this doctrine, particularly in relation to keeping the worker safe. The second is the doctrine of necessity. This arises when non-treatment interventions of a last resort are used primarily for the purpose of protecting the adult from harm. Again, acting honestly and without negligence are important considerations in attracting these immunities. Therefore, QAI fail to see the need to broaden the current immunity provisions. Further, we are not aware of any service provider or individual who has been prosecuted for using restrictive practices without an order under the current provisions.

The need to seek strengthened immunity provisions is motivated by the delay in obtaining approvals or consent. This delay is from a number of factors, either service provider or decision maker based. Rather than providing immunity, it would be more appropriate to require diligence in

making or applying for such decisions. This could be achieved, for instance, if time frames are introduced in which a decision maker must make a decision. In the case of a new application or applications to the chief executive officer, for example, a decision could be made within 24 to 48 hours. There is also the possibility of applying for an interim order under current section 80ZR in the Guardianship and Administration Act. Perhaps this provision needs to be broadened to include all uses of restrictive practices. In the case of ongoing approvals, the time frame in which the decision maker must make a decision should be limited to 30 days. However, the service provider would be required to make the application at least 30 days before that approval has expired.

In relation to the immunity provisions, we are not 100 per cent sure how they are going to operate, so we would just like to ask some questions or get some clarity around those provisions. In particular, the short-term approvals are for a maximum of six months. Will the 30-day immunity period form part of that six-month period so that any approval has a retrospective effect or will it be additional, in effect, making the short-term approval seven months? We would recommend that there is a retrospective effect.

The immunity provisions also allow an adult to be subject to restricted practices without an order or authorisation for up to 30 days whilst awaiting approval. If the decision maker deems restrictive practice is not necessary, the adult has then had their rights infringed for 30 days, but on what grounds and what element of review is possible to review this situation?

Some of the wording is not clear and should be stronger. For instance, what is meant by 'being implemented' under clauses 17, 22 and 24? Does this mean the positive behaviour support plan already needs to be in place or simply that it is being developed? We recommend that this should be amended to read along the lines of 'A positive behaviour support plan or respite community access plan must be in use'.

Clause 17 does not make it clear if immunity will be given if the adult does not have a positive behaviour support plan or respite community access plan. For instance, if this is the first time the adult has displayed challenging behaviours, will immunity still be provided, given that one of the criteria for attracting this immunity is having a positive behaviour support plan or respite community access plan in place.

The effect of clause 22 is that the decision maker is provided with a 60-day period in which to make a decision about the use of restrictive practices other than seclusion and containment. This is an extraordinarily long period given the seriousness of using restrictive practices. Diligence is required to make this decision earlier. The introduction of time frames, as suggested above, may address this.

Restrictive practices impinge on an adult's human rights—in particular, the right to liberty, security of the person and the right not to be subject to cruel, inhumane or degrading treatment or punishment. Therefore, we would like the see greater legislative emphasis on the need for the adult to be provided with legal representation and/or advocacy if these immunity provisions go ahead. Increasing the right or access to legal representation or advocacy meets both the second and third focus of the bill; namely, enhancing safeguards for the adults subject to restrictive practices and improving the care and quality of life of adults with challenging behaviours.

Some secondary concerns we have about the bill—and I will just mention these very briefly—include the approval for the use of restrictive practices for seclusion and containment by service providers who propose to provide disability services to the person, under clauses 47 and 48. The effect of these clauses is to allow a service provider not currently providing disability services to an adult to be approved to use seclusion and containment and other forms of restrictive practices if they propose to provide disability services. QAI believes this could pre-empt the use of restrictive practices where the need does not exist. For instance, the proposed service provider may apply to use the restrictive practices just in case or feel obligated to apply because of pressure from other parties. This is not the least restrictive approach and does not presume restrictive practices will be used as a last resort. QAI is concerned that these provisions may negatively stereotype the adult in that their reputation precedes them, yet that reputation could be wrong.

By way of an example, QAI acted in a matter where the adult was subject to 24 hours containment and up to 12 hours seclusion per day as well as other forms of restrictive practices. At an urgent QCAT hearing to stop the transition to a new service provider, both the Department of Communities and the old service provider expressed concerns that the new service provider did not propose to use restrictive practices and that these restrictive practices were needed to keep both the community and the person safe. The new service provider, however, wanted to wait until after they had undertaken their own assessment and had a chance to become familiar with the person

before deciding on whether to use restrictive practices or not. The new service provider has never seen the need to use or even to apply for the use of restrictive practices. QAI recommends that the prohibition on a new service provider getting a short-term approval should remain until that adult is under their care.

In regard to the reporting provisions in clause 36, QAI generally welcomes the increased reporting provisions as appropriate data collection will help to determine the effectiveness of the positive behaviour support plan in reducing the use of restrictive practices. This is current not currently possible due to a lack of publicly available data. Our concerns in this area centre on not knowing what data is actually proposed to be collected from the service providers. The amendments simply refer to information that is prescribed under a regulation. We would like to see some certainty around this area. In other words, we would like to have some indication of what data will be collected. Data collection should have purpose beyond research, so it should be linked to reporting obligations, be transparent and be publicly accessible if de-identified.

Finally, we have concerns with the length of the restrictive practice guardian appointment in clause 43. The GAA, or the Guardianship and Administration Act, currently provides that this appointment is for one year. The amendments propose to increase to it to two years because of the resource intensity for appointing restrictive practice guardians. In our experience the appointment of a restrictive practice guardian has had little involvement from the service provider. The resource intensity issues in our experience arise when the service provider challenges either the appointment or the decision of a guardian. QAI is opposed to such an increase as it presumes that there will be a need for restrictive practices for two years, and we do not believe that this is the least restrictive approach. However, QAI may be willing to consider an increase provided there are regular reviews undertaken during that two-year period. QAI is of the opinion that, if the PBSP is of a good standard, these reviews will not be onerous as the service provider could readily demonstrate an improvement.

CHAIR: Thank you. Mr Collyer, do you have anything further to add?

Mr Collyer: Thank you, Chairman. I would like to reiterate what David said about the immunity provisions in clauses 17, 22 and 24. A little bit of context might be useful for the committee. The restrictive practices legislation grew out of some reports that were written in the 1990s—really not that long ago. They were reports by Justice Carter and Justice Stewart into some occurrences at the Challinor Centre, west of Ipswich. There were significant abuses going on at those places, and the reason that those abuses were happening was that there was insufficient monitoring of what was going on. Essentially the service providers had carte blanche to carry out their services in the way that they wanted without scrutiny. I think it is important when considering these amendments to consider that it is the scrutiny and the possibility of scrutiny that ensures that service providers provide these services in a way that is consistent with people with disabilities' human rights.

So, in terms of the immunity provisions, clause 18 actually allows a service provider to make an application or essentially fill out a form that specifies that they would like to use restrictive practices. They lodge the form and then from that point for 30 days they are able to implement those restrictive practices without scrutiny. We are concerned about that. I would like to reiterate what David said about that.

CHAIR: Thank you. I will open it up to the committee if there are any questions from anyone at this point in time. This is an incredibly complex circumstance and every situation is different. I am always interested to hear various views and concerns and considerations. One of the things we spoke about with the folks from Endeavour was monitoring of the implementation of the restrictive practice plans. Am I understanding you correctly that that is also one of your concerns, that you would like to see monitoring? One of the comments I made then was about external monitoring—and we just spoke about it with the Law Society—having someone who is external to have a look at that.

Our intent always is that we want to maintain the integrity of our democracy by ensuring the rights and liberties of individuals and that when we are taking those rights and liberties away it is done lawfully and it is done for the right reasons. Am I understanding you correctly that really what you are saying is we need some different eyes on this? As you say, even the threat of potentially monitoring sometimes is enough to keep people on the straight and narrow. I know in business, for example, I would do 10 per cent auditing and across the organisation they did not know who was going to be audited. That in itself was sufficient enough to make people say, 'I'm going to get measured here. I'm going to get looked at here.' Are we on the right track here? Is that what you guys are talking about?

Mr Manwaring: It is exactly what we are talking about.

Mr Collyer: We held a forum recently and we brought some experts up from around the country, and one of them was Lyn Webber from the Victorian equivalent of disability services. Her job down there is to monitor the quality of plans. One of the things I remember her saying at the forum was that, if you monitor the quality of plans, audit them for quality and you get them above a certain level of quality, you get a significant reduction—I remember she was talking about physical restraint in that particular example. So, yes, we think that auditing of plans is very important. Of course, to audit them you need to know what is in them, and that is why we need this reporting provision which I presume will be fleshed out in the regulations.

CHAIR: Is there anyone else who wants to ask a question?

Dr DOUGLAS: It is a devil's advocate thing. It is about the issue of immunity and the issue you have raised about immunity provisions. The difficulty has been in managing these people. If the immunity provisions are not reasonable, no-one will look after these people. Are you aware of that? Are you aware of what has happened previously?

Mr Manwaring: Yes, we are aware of that. We have dealt with that in our practice and often we do hear from service providers that if they do not get certain requirements then they will not provide care to the person. We, however, think that there can be a compromise and that we do not need to provide 30 days immunity to a service provider. We think there is ample time given the number of people who are under restrictive practices in which a decision maker could make a decision because that decision maker is not just one person. That decision making is devolved to other people. So one decision maker could devolve that responsibility to 10 other decision makers.

The figures from the hearing a week or so ago I believe showed that about 500 to 600 people are currently subject to restrictive practices. That equates to two approvals being reviewed every day. Given the number of possible decision makers there, I think it would be timely to have a decision made in X period of time. I used the 24 to 48 hours previously and that would be in an emergency situation. If approval is not given in that time, then there is also the process which I alluded to which was applying for an interim order to use that restrictive practice for the possibility of up to three months. Clause 22, I think it is, provides a 60-day period in which a decision maker can make a decision. I have some concerns about that. I am not saying exactly what I am saying is correct, but I think this needs a little more scrutiny in terms of providing what I see as pretty much a blanket immunity for the use of restrictive practices. I just have the feeling, and from practice the experience, that this will present some challenges at a later time, but as I have indicated if these immunity provisions are brought in I would like to see the strengthening of an adult being able to have recourse to some sort of advocacy or legal representation.

CHAIR: Unfortunately, we are out of time. Thank you for your interest. We look forward to your submission.

COOK, Ms Jodie, Public Advocate, Office of the Public Advocate

CHAIR: Welcome back, Ms Cook.

Ms Cook: Thank you.

CHAIR: We appreciate your time with us today. I invite you to make an opening statement.

Ms Cook: Thank you again for inviting me to appear before you this morning. In my role as Public Advocate for Queensland, I am responsible for promoting and protecting the rights of adults with impaired decision-making capacity. From our estimates, we believe there are up to 114,000 people with impaired decision-making capacity in Queensland, approximately one-quarter of whom have an intellectual disability and a further 15 per cent a cognitive impairment. Of this number, we also estimate that up to 20 per cent may access specialist disability services. While not all of these people exhibit behaviours that would result in them being subject to restrictive practices, those who do represent a significantly vulnerable and marginalised group of individuals, and the potential, I guess, for this bill is that it may impact many such Queenslanders.

In considering this bill, it is important to understand that challenging behaviours are not a failure of the person; they are a failure of the system around the person. We should also be clear that challenging behaviours are deemed as such because they are challenging for those supporting the person. They are rarely challenging for the person because, at its essence, behaviour is functional in nature; it serves a purpose. For many people with intellectual disability or cognitive impairment, behaviour is a means of communicating. When a person engages in a behaviour the service provider finds challenging, the person is usually trying to express themselves. They are saying, 'I do not like that,' 'That's not what I need,' or 'I'm in pain, help me.' Despite what a person might be trying to convey, if those supporting them do not understand what they are saying then the person's needs are unlikely to be met. Over time this lack of understanding becomes increasingly damaging. The vulnerability of the person ceases to be recognised and instead they are labelled as challenging. They become a problem to be dealt with as opposed to a person to whom we should accord dignity and respect.

Five years have passed since the introduction of the regulatory regime and the other complementary systemic reforms aimed at reducing restrictive practice use in Queensland. These reforms also aim to facilitate improved outcomes and ensure appropriate safeguards and protections for people with disability subject to such practices. Given the time that has passed, it remains concerning that there is little or no evidence regarding the effectiveness to date of the regulatory regime and/or the complementary systemic reforms in reducing or eliminating the need to use restrictive practices. Furthermore, despite the bill's focus on reducing red tape, there is little evidence on which to base an objective assessment of the extent to which any undue compliance burden that can be directly attributed to the regulatory regime exists.

At its essence, the use of restrictive practices is a significant infringement on a person's human rights. It is also potentially unlawful and may give rise to criminal or civil liability. Therefore, while I support the intent of the bill to the extent that it includes provisions that focus on improving care and quality of life, my support is qualified by the view that any streamlining of processes should not reduce safeguards. While I acknowledge and respect the views of service providers and commend their efforts in implementing a positive behaviour support approach, I remain focused on ensuring that restrictive practices are only ever used as a last resort, that appropriate protections are applied and that their use is strictly monitored.

With this in mind, I am concerned that the bill may not achieve its stated objectives and that it is weighted more in favour of addressing resourcing issues for service providers than on upholding the rights of the people it is designed to protect. For example, in the interests of reducing red tape it would appear that the safeguarding provisions may in fact be lessened by the bill. Rather than consolidating the gains made in the sector by upping the ante or at minimum maintaining the status quo, this bill downgrades existing safeguards by allowing immunity for service providers to use restrictive practices without necessarily having an appropriate consent or approval in place. In lieu of the proposed 30-day immunity provisions, I would respectfully recommend that the legislation instead allow decision makers to make an interim short-term approval or interim consent with conditions that must be met and time frames for response. While still enabling immunity, this option also ensures an independent judgement about the appropriateness of those practices.

Moving on, I am also concerned that the proposed amendment to the definition of chemical restraint may create uncertainty with respect to the definition of health care in the Guardianship and Administration Act 2000. While I understand the intent behind the proposed amendment, there is no specific provision in the Guardianship and Administration Act that allows for sedation of adults to

facilitate health care. It may therefore be presumed that such sedation would constitute health care that can be consented to by a statutory health attorney or other such decision maker. While this may be reasonable if the adult is being sedated by a dental surgeon or an assisting anaesthetist, for example, it becomes more doubtful if the adult is sedated by the service provider prior to getting in the car to go to the dentist or doctor. In the interests of ensuring that the proposed amendment does not create unnecessary uncertainty, I would respectfully suggest that this amendment be excluded from the current bill and be subject to further consultation with those who have expertise in health law and guardianship, which I do not believe has taken place to date.

Despite these concerns, I, too, would like to acknowledge some of the positive aspects of the bill such as mandatory reporting, a minimum standard for effective positive behaviour support plans through the model plan and the requirement to ensure that the adult understands his or her rights in respect of any proposed use of restrictive practices. Legislation, however, is a blunt instrument for achieving the type of cultural change that is required to make a difference in the lives of those people for whom this bill applies. Arguably, a true cultural shift will only be achieved when service providers understand and uphold in practice a rights based approach to the way in which they support clients.

In closing, I commend the bill for those elements that provide a framework by which service providers can better ensure that the rights of adults are understood, communicated and upheld. However, I reiterate my concerns with respect to the immunity issue and the definition of chemical restraint, and encourage the committee to consider my recommendations as a means by which to better protect the rights of those adults who are subject to restrictive practices. Once again, I would like to thank the committee for allowing me to speak today. While the issues that I have raised today as well as some others will be further detailed in my submission, I welcome the opportunity to respond to any questions you may have.

CHAIR: Thank you, Ms Cook. Are there any committee members who want to ask Ms Cook a question?

Dr DOUGLAS: Thank you for your excellent presentation. Are you saying that you do not see a role for a defined restrictive practice at this point in time? Do you think we have not got to that point now? I was not certain that you were saying you thought we had got there yet.

Ms Cook: No, I do not believe we have. I guess in that respect I am concerned that we are perhaps taking a step backwards with some of the amendments that are proposed at this point in time. Given the state of play prior to the original legislation coming into force, I believe the sector is making some reasonable gains. However, there is no concrete evidence of that. To that end, that is why I definitely support the idea of mandatory reporting. I think that evidence has been sadly lacking and if that reporting had been in place from the word go I think we would have greater evidence on which to base any proposals for amendment.

CHAIR: I have just missed it, but what is your reaction to the statement of rights in the bill?

Ms Cook: I think the statement of rights is an excellent addition to the legislation. Probably what I am more concerned about is the support that may be required by an individual to exercise those rights. The statement in and of itself, if it is explained appropriately to the person, will go a long way to seeing them be able to contribute and be part of any proposal to use restrictive practices.

CHAIR: Again, this may be simply my ignorance: if the person is under the guardianship of the Adult Guardian, wouldn't the Adult Guardian be responsible for ensuring those persons' legal rights were properly represented?

Ms Cook: I think that is true in its intent. I cannot comment on whether that actually occurs in practice. I do not have evidence to support a statement either way there.

CHAIR: But as far as the legislation is written and the intent of the legislation, that would be accurate?

Ms Cook: I would certainly see that as part of the responsibilities of any guardian given the general principles of the Guardianship and Administration Act.

CHAIR: The majority of folks under restrictive practices have an appointed guardian, whether it is an Adult Guardian or a relative. So, again, that same principle would apply in that there are rights within the bill that would apply and it would be the guardian's responsibility to ensure that that person's rights are properly represented?

Ms Cook: It is probably a practice challenge more than a legislative challenge. I think the practice is that many private guardians—perhaps not the Adult Guardian, who would have, hopefully, a full understanding of the Guardianship and Administration Act—may not understand their obligations. They may not have read the act in its entirety. They may not have a full understanding, for instance, of what the general principles are and/or how they should be applied in practice. That is certainly an area where I think there should be further education for guardians.

CHAIR: I am trying to understand it. My reading of it—and, again, it may simply be my ignorance—is that it is a pretty good attempt to make sure that people understand that everyone has rights.

Ms Cook: Yes.

CHAIR: And that is a cornerstone of our democracy. If people were not impaired cognitively or mentally then they would not have a guardian, and in normal society they have access to the same legal rights as everybody else.

Ms Cook: Yes.

CHAIR: So I am just trying to make sure that we are talking about practice here; we are not talking about legislation.

Ms Cook: No. I am supportive of the statement of rights. As I said, I think it is a good first step. I think the translation of that to practice and the support to exercise those rights is something that is much needed.

CHAIR: So there may be a need, for example, around an education process for carers to ensure that they understand that the person they have guardianship over has rights and what those rights are, especially where restrictive practices are a possibility.

Ms Cook: Definitely.

CHAIR: Does anyone else have any questions at this point?

Dr DOUGLAS: I have one more. I just want to expand on this a little bit here. I accept what you are saying about the issue of mandatory reporting and that sort of stuff. We are moving into an environment where we have the NDIS coming. Yet you have said that we have this process that we are trying to make this happen, but we are not there yet. I am having difficulty—would you have us just leave us where we were? Is that what you are saying?

Ms Cook: No, not at all.

Dr DOUGLAS: What is so deficient within this? You have mentioned immunity—actually I accept some of the issues that were raised by the advocacy people earlier. I am unclear. Is it a quantum type thing or is it just subsections of this legislation?

Ms Cook: Taken piece by piece, there are no doubt valid reasons for the legislative amendments. I am not against the intent of the bill. In fact, as I indicated in my opening statement, I am supportive of the intent of the bill, particularly to the extent that it does enable increased safeguards and protections. I think what I am concerned about is that there are number of elements that I believe lessen those protections. I think allowing immunity for a service provider to use practices without someone having an opportunity to independently look at whether it is an appropriate response to the situation is potentially damaging. I think it runs a very serious risk to the person that practices are being put in place without having been considered for the context around that person.

Dr DOUGLAS: Is it a critical flaw?

Ms Cook: Absolutely. Behaviour is context specific. It is premised on the environment around the person. In many respects people would not use behaviour if someone who is supporting them, whether that be a family member or a service provider or whoever, understood what that behaviour meant for the person.

Dr DOUGLAS: Are there other critical flaws that you see in terms of even in a hierarchical form? You have said that is probably the critical flaw.

Ms Cook: There are probably some other things that could be attended to and they are things that I have raised at different times. While I do not have an issue in and of itself with removing the requirement to keep and implement a policy, I am concerned that within that section in the legislation as it currently stands was the requirement for review. Although under the amendments, within section 123L—the requirement for a positive behaviour support plan—it is

proposed that there must be a requirement to state the time frames for review, there is no positive obligation to actually undertake a review. Again, that could be fairly easily attended to by perhaps some additional provisions.

Dr DOUGLAS: Thank you.

Ms Cook: In my submission I will actually not just point out what I am concerned with but also offer recommendations to that effect.

Mr SHUTTLEWORTH: Ms Cook, if no immunity were provided, how would a service provider effectively balance the protection of their workforce and the protection of the rights of an individual?

Ms Cook: I guess the reason behind the alternate option that I have put forward is to enable that immunity still to be there. So by allowing for an interim approval—for instance, if it was a short-term approval or if it was an ongoing consent—the Adult Guardian or, in the case of short-term approval, the chief executive could actually say, 'Yes, I hear what you have said. I believe that you are right. There is likely to be a level of risk there. I am going to give you this interim approval but you must provide me with X, Y and Z within seven days at which point I will actually give you that,' or 30 days for that matter. But that person has independently looked at that circumstance and therefore given the immunity on the basis of an independent perspective. So I am not saying that we should take out the immunity entirely but put it within a context where there is an independent person looking at what the request is about and therefore making an assessment of whether it is needed or not.

CHAIR: So again we are talking about an independent monitor in effect.

Ms Cook: At the early point of approval, not just subsequent to the practices being in place.

CHAIR: And again the very threat of that occurring may in itself drive a positive behaviour by the service providers.

Ms Cook: Yes. I guess I am just concerned that, if the provisions go through as they are, effectively—and I cannot remember which of the previous speakers pointed to this issue; it may have been QAI—a service provider could put up their hand today and say, 'I want to use this practice,' and just go ahead and use it for 30 days without anyone looking at it in that time frame to deem whether it is appropriate and/or whether there is any level of risk to the person from using that practice. That is 30 days in which someone is potentially subject to or at risk of significant harm as a result of the practice itself. As an example, prone restraint is something that has led to death with people, yet it is still a practice that is used. What is to stop a provider from saying, 'I want to use prone restraint,' using it for 30 days and the client dying within that period of time? There is nothing to stop it with those provisions.

CHAIR: Just so I am clear on this: what you are advocating is that a service provider could call the chief executive and say, 'I have an emergency situation here. Here is a circumstance. I would like to implement the following restrictive practice.' The chief executive could say, 'I hear what you are saying. I approve that but within seven days I need to have proof on my desk or a case definition or whatever it is on my desk so that I can properly assess that.' Is that what you are suggesting?

Ms Cook: Yes or 30 days if they want to give that. Again, I would not say that that time frame should be indefinite.

CHAIR: So it is an independent review. If in fact the good faith exhibited by the chief executive were abused by the service provider, then would you envisage a provision of penalty of some sort?

Ms Cook: Well, additional. If you were to put in place provisions that allowed for that interim approval, then I think you would also need to have in place provisions to enable that approval to be revoked.

CHAIR: Thank you. We have run out of time. I appreciate your time. I appreciate your effort in this and we look forward to your submission.

Ms Cook: Thank you.

CHAIR: I welcome at this time Ms Joanne Jessop, CEO of Multicap.

JESSOP, Ms Joanne, Chief Executive Officer, Multicap

CHAIR: Good morning. Ms Jessop, I welcome you to our hearing. Please, I invite you to make an opening statement.

Ms Jessop: Thank you. I am here representing Multicap. Multicap is a Queensland based specialist disability service provider, and we have been supporting individuals with high-support needs and complex behaviours for over 50 years across the state. Multicap has been involved in supporting individuals subject to the restrictive practice legislative requirements since the amendments were first introduced in 2006 as part of the transition plans, and we are one of five organisations that carry a significant percentage of individuals that are subject to this legislation across the state. We currently have 51 individuals who are subject to these legislative requirements and we have approximately 33 individuals who are no longer subject to the requirements due to improvements in their behaviours of concern and because they have moved services or service providers.

We currently support individuals who are subject to all the defined types of restrictive practices defined in the legislation including seclusion; containment; physical, chemical, mechanical restraint; restricted access to objects; and locked gates, doors and windows. We actually currently support three individuals who are subject to seclusion and containment. That is the lowest number for our organisation since this legislation was introduced. There is significant anecdotal evidence across the sector of improvements in people's lives due to this legislation and the practices that have occurred as a result of the legislation. In line with our organisational values around quality of life, we also have five individuals who currently have positive behaviour support plans who are not subject to the legislation, and that is about improving people's lives rather than being driven by legislative requirement.

We actually fully support the intent of the legislation and always have. It brings a focus on the causes and the triggers for behaviours for individuals and it assists in developing new ways of improving people's lives by introducing strategies that will reduce these incidences of behaviour. A good example is a young lady we support in Mackay. In 2006 she had approval for seclusion, chemical restraint, physical restraint and restricted access to objects. In her most recent review, her physical restraint has been made least restrictive, her chemical restraint has been reassessed and is now for the proper treatment of a mental health condition, and she has not been under seclusion for some time. So clearly she has a better life than she had in 2006 when this legislation came into play.

We have, however, advocated from 2006 that the compliance requirements of the current legislation are unreasonably burdensome for service providers and that a shift in focus from compliance to the legislation to demonstrated outcomes that would be more beneficial for individuals is really essential. So, from our point of view, the improvements in people's lives have come more from increased awareness, increased investment in resources in the sector and increased access to expertise and evidence based practice for service providers and families than because of the legislative compliance and the legislative regime. So we are generally very supportive of the amendments that are outlined in the bill.

CHAIR: Thank you. I have a couple of questions for you. We have heard from different people today regarding the liability issues and I would love to hear your thoughts as a provider in regard to the liability issues as they are written in the bill.

Ms Jessop: The immunity for service providers has been an ongoing challenge. It is essential that organisations can practice in a way that is safe with their staff while maintaining the human rights of the individuals that we support. I have a view that service providers inherently have noble intent. So nobody goes out in the morning to decide that they are going to ruin someone's life or cause someone harm through a day. On the whole, staff in organisations like ours have the best possible intent and the best possible belief that everybody has a right to a quality life.

So the immunity issues for us come from areas that are outside our control. So, while our staff might do all that is required under the legislation from their point of view around writing plans, getting them to the guardians, putting in the short-term approvals, the approval of those short-term approvals and the consent of new plans through the Adult Guardian are outside our control. So we get all the paperwork in and it meets all the requirements under the legislation but it is not approved in time. So it puts our organisation outside the legislative framework and at risk because we do not have immunity.

So from our point of view this 30 days is actually essential to good practice in our organisation and to ensure that we can safeguard our organisation and our staff over those periods of time where workload through the Adult Guardian or through the short-term approval process is not managed in a timely way. We will get our plans into the Adult Guardian 30 days before the plan is due to end its consent as requested, but it does not come out the other end in time. So we are put in this invidious situation of do we stop supporting the client? Do we put them and others at risk? Because that is the whole definition around a restrictive practice to start with, that it puts the person themselves or others at risk of harm. So that is an essential change for us and we have been arguing for that right from the start. We have no control over the time frames and it is unreasonable to put an organisation at risk.

CHAIR: So, irrespective of your own internal practice, the risk of liability comes as a consequence of things you cannot control as an organisation, being the approval process coming from either departments or medical staff or wherever it has to come from.

Ms Jessop: That is exactly right.

CHAIR: I appreciate that and others may want to follow that up a little bit further. Can I just talk to you a little bit about the reporting focus.

Ms Jessop: Yes.

CHAIR: I think you said you would love to see it move from compliance to legislation and regulation more to outcome. Would you propose then that there would be a standard report? Because with legislation and compliance to legislation you say, 'These are the things I have to comply with because that is what written down.' How do you determine outcome based reporting, because everyone is different—especially when we want to try to move the person off a restrictive practice? How do you determine that? Would this be a report per person based on the plans that are in place? How would you determine that?

Ms Jessop: I think the data reporting is really interesting because the five organisations that have carried the majority of clients have actually been providing data to the department right from the start of this process. We record internally what is happening with our individuals and we have been feeding that information back to the department. While it has not been mandatory reporting, as I said at the start, the intent of the legislation is very positive and we have all wanted to see improvements in people's lives. We could give you information from our organisation about the number of people who have less practices now under the restrictive practice regime than they did at the beginning. I think if the reporting is tied back to what is achievable in a plan and the strategies around improvements in people's lives, then you are reporting benefits rather than legislative requirements. There are some simple ways I think we could do that. There is a current My eRecord project in Queensland run by some of the disability service providers. Rather than investing in a whole new database for reporting, we could use a methodology like that which is around the person and what is happening for the person and provide the data that I think we need and outcomes.

CHAIR: So this could be tied into external monitoring?

Ms Jessop: I think if we need external monitoring to prove that restrictive practices are reducing for people then, yes, but it cannot add another burden in compliance to organisations because you may or may not be aware that organisations do not get any additional funding to support a person who falls under this legislation. We get the same amount of funding to support a person with all this compliance with this legislation as we do for any other person under specialist disability services, but the actual workload and onus on the organisation around these individuals is so much more than for a person who does not fall under this requirement. If you then add mandatory data reporting and you add having to ring the chief executive to get your immunity covered, there is no resource to do that. So it is an argument about resource versus benefit.

CHAIR: Thank you.

Dr DOUGLAS: I do not want to paraphrase you, but your experience with it since the trial started is good? It is positive?

Ms Jessop: Absolutely. We have significant positive improvements for the individuals that we support around their behaviours of concern.

Dr DOUGLAS: The Public Advocate was concerned about the issue of mandatory reporting; that it was not engaged with and so was a deficiency. But you have said that to all intents and purposes the reporting has been as thorough as it needed to be or it could have been; is that right?

Ms Jessop: From our point of view, yes. We have evidence internally in our organisation of the improvements in people's lives as a result of the changed practices and the increased resources that were put into the sector around the specialist practice. I know that the other four organisations have got the same.

Dr DOUGLAS: And the staff are comfortable with the changes to this point? Have you had a lot of movement of staff as a result of these—

Ms Jessop: The sector has a high turnover of staff.

Dr DOUGLAS: I know that.

Ms Jessop: On the whole, staff who have a values base and a passion for working with complex behaviours stay in that area of practice. I think what we need to try to do is get away from paper and get back to having the person at the centre of our practice, so less compliance and more focus on outcomes.

Dr DOUGLAS: That has been a point well made by a few others as well. From your point of view, the deficiencies, if I am correct, are that it is not as outcomes based as it could be, it could use an external database which you mentioned, My eRecord?

Ms Jessop: Yes, I think there are a number of ways of doing it.

Dr DOUGLAS: And that could be used for monitoring.

Ms Jessop: Yes.

Dr DOUGLAS: It is not doing that yet. What were the other deficiencies?

Ms Jessop: In the current bill?

Dr DOUGLAS: Yes.

Ms Jessop: I think the deficiency around gaps in immunity to allow organisations to work through in the best interests of individuals. I think there are also some gaps around strengthening families as guardians. We seem to have somehow created a system where the natural default is the Adult Guardian as the decision maker because the families are not well informed or do not feel that they have the ability to be the guardian. I think that is an unintended consequence. I am not sure that the amendments in the bill help us move back towards families being more empowered. I think they might move us a little more the other way. I am a bit of a pragmatist so you can only do one thing at a time with this. We have the NDIS coming and that will mean this is going to need complete rethinking anyway.

Dr DOUGLAS: I sympathise with that position. I am a medical person and I know there is a high exhaustion rate in families with regard to these types of people just as there is with staff. Exhaustion in families sometimes leads to some of the things I suppose that the legislation was seeking to pick up. Is there a way of managing that better? Families sometimes start excluding these people. Is there a way of better doing it? You have alluded to the fact that you think it is a weakness. How do you improve it?

Ms Jessop: From our point of view it is probably about constant education of families and making it easy for them to be engaged. I think that statement that is included in the new amendment to the bill goes some way to doing that, about trying to engage families and decision makers in the process rather than allowing them to let the Adult Guardian do it on their behalf.

Dr DOUGLAS: Thank you.

CHAIR: One of the things we have seen come through consistently today is external monitoring or the threat of external monitoring on service providers. Do you have any thoughts on that?

Ms Jessop: As in the threat of external monitoring might drive a practice in—

CHAIR: Right, might drive a practice of compliance against plans, for example?

Ms Jessop: I take the point of view that I do not think that changes behaviours in service providers necessarily. Again, I believe most service providers and most staff have noble intent when it comes to working in this sector. I understand we have both ends of the spectrum so you do need legislation to cover some of that baseline, but I think people work in this area because they believe that people deserve to have a quality of life. I am not sure if that answers your question.

CHAIR: In your experience, would there be benefit to the individual in having an external monitoring process?

Ms Jessop: I think if you are looking across the spectrum I would not object to external monitoring.

CHAIR: Being a former CEO of a very large not-for-profit, I do take your point about it potentially turning into a burdensome activity that has no particular compensation associated with that to the organisation. I am not talking necessarily even monetary. There are different ways that those things affect people, but I have to say I do take the point that sometimes when left unchecked irrespective of a person's noble intent the reason I think we have a high turnover in the sector is because of the incredibly complex nature of what we deal with.

Ms Jessop: Yes.

CHAIR: I think sometimes the sheer frustration of day after day after day going to work in circumstances where it is very difficult leads to unwittingly engaging in practices that necessarily in different circumstances you would never as an individual do.

Ms Jessop: I agree that the legislation refocused people's attention on practices that were less than ideal. It has driven an improvement in practice across the sector, but I did want to make the point that that comes also because of the increased resources and expertise that was put into the sector with the centre of excellence, the SRS teams and all the clinicians because that did not exist before. So you have two things working in parallel. You cannot change one without understanding that it impacts the other.

CHAIR: A point well made. If there are no other questions at this point, thank you for your time. I assume you are putting a submission through to us?

Ms Jessop: Yes.

CHAIR: I thank all witnesses and I declare this hearing of the Health and Community Services Committee closed.

Committee adjourned at 11.25 am