Royal Commission
into Violence, Abuse, Neglect and Exploitation
of People with Disability

Statement of Simon Wardale

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Date: 9 September 2020

1. This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. This statement is true and correct to the best of my knowledge and belief.

2. I make this statement on behalf of Multicap and I am authorised to do so.

Professional background

3. I am currently the Chief Clinical Practice Officer at Multicap. I have been in this role since July 2019, and have been employed at Multicap since June 2018. I explain my role and Multicap further below.

4. I have a Bachelor of Applied Science (Honours) with a major in Intellectual Disabilities.

5. I have worked with people with intellectual disability who use challenging behaviour for the past 30 years. My roles have included front line support work, service management, and practice / policy advisor. In the past ten years I have held the positions of Director of Practice Leadership at the Centre of Excellence for Behaviour Support (University of Queensland / Queensland State

Government), Director of Forensic Disability (independent statutory appointment), National Manager Specialist Behaviour Services (Endeavour Foundation), and General Manager, Specialised Services (Multicap). I have been published in academic journals on issues relating to behaviour support training, quality, and outcomes for offenders with a disability presenting to court.

6. The document marked **MCP.9999.0001.0001** is a copy of my CV.

Introduction

7. The term 'Restrictive Practice' is generally used to describe a suite of strategies or techniques used in response to behaviour that can cause harm. Central to the definition of Restrictive Practice is the impact such techniques have on restricting the rights or freedom of movement of a person with a disability[1][2][3]. The collective concern regarding the use of Restrictive Practices arises due to the combination of both the paucity of clinical evidence supporting their use, and the ethical implications of imposing upon a person's human rights.

8. Central to the issue of Restrictive Practices is therefore a collective concern for the wellbeing of people who, by definition, present a risk of physical harm to themselves or others. Whilst this risk is significant in and of itself, the issue of restrictive practices involves further risks relating to failed service delivery, inadequate access to, or coordination of healthcare, and mistreatment as a result of poor practice. The risk of a person with disability living an unfulfilled or undignified life is perhaps the most concerning risk of all. To maximise the greatest potential for life quality for people with disability, it is both my opinion, and the opinion of Multicap that:

   a. Supporting people with intellectual disability and challenging behaviour is a specialised endeavour requiring a targeted, whole of organisation response. At a minimum this must integrate clinical, operational and human resource

[1] NDIS Act, Australian Federal Government (2013)

[2] Disability Services Act, QLD Sate Government (2006)

[3] Disability Act, Victorian State Government (2006)

functions and be explicitly supported at both senior leadership and a governance level;

b. Many disability support organisations do not maintain, nor do they seek to maintain, this integrated capability;

c. Accordingly, funding and policy initiatives should be structured to support people with intellectual disability and challenging behaviour to access services from organisations with this demonstrated capability;

d. Funding and Policy initiatives must support this integration of clinical, operational and human resource functions;

e. Policy initiatives, and in particular regulations relating to restrictive practices, should be designed to support practical application of behaviour support at a direct, operational level.

Multicap

9. Multicap's vision is to be the leading source of creative and sustainable support options for people living with a disability, particularly those with high and complex needs. Our sole purpose is for the quality of life of people living with a disability and their families to be enhanced by our support. We achieve this by working collaboratively alongside people with a disability, their families and each local community we are part of to design and deliver supports that assist our customers to exercise choice and control, and develop independence.

10. Multicap is one of Queensland's most established disability service providers, with 58 years of experience in supporting people with complex and multiple disabilities as well as their families. In 1962, Multicap was created by just five Queensland families who were turned away from everywhere they approached, and who were struggling to find suitable support for their children with multiple disabilities. Almost 60 years later, Multicap has continued to innovate and evolve into is a multi-faceted support service that is responsive to the changing needs and requests of our customers, and is now assisting more than 1200 people with disability and their families, as well as creating employment opportunities for over 100 people with disability, backed by a team of more than 1100 staff.

11. Multicap empowers people with disability by providing individualised support through a network of one-on-one and group service supports and programs. Services including hub and community-based recreational and skill development activities, employment, creative arts, independent and supported living options, positive behaviour support, and medium and short term accommodation that are delivered from more than 100 rural, regional and metropolitan locations across Queensland and Northern New South Wales. Multicap aims to deliver high quality services and supports that are responsive to individual needs and requests, whilst remaining viable in an increasingly competitive environment.

12. As Chief Clinical and Practice Officer my role is to support Multicap to design and deliver evidence based services for people with complex needs, and in particular, those who use challenging behaviour. I am operationally responsible for a team of behaviour support clinicians, support coordinators, after hours / on call managers, and two highly specialised purpose-built Medium Term Accommodation houses. These houses provide accommodation options for people in crisis, often as a result of other service providers being unable to meet the customer's needs. The intent is to stabilise the person's crisis, integrate clinical and other services, and assist the customer to secure stable, long term accommodation and support. The transitional nature of this service model facilitates an active focus on customer success, whilst ensuring the service is able to respond to people who may experience crisis in the future.

13. I work particularly closely with Multicap's Chief Operating Officer and Chief Employee Experience Officer to deliver the integrated response to the complexity outlined above.

Regulatory framework for restrictive practices in Queensland

14. Based on my experience, it is my view that the regulatory reforms in Queensland that followed the Honourable Justice William Carter's report[4] were pivotal in

[4] Carter, W. J. (2006). Report to Honourable Warren Pitt M.P. Minister for Communities, Disability Services and Seniors: Challenging Behaviour and Disability, a Targeted Response.

improving practice in the support of people with disability and challenging behaviour.

15. As was Justice Carter's stated intent, the Queensland regulatory framework for Restrictive Practices represents careful consideration of key elements of the discipline of Positive Behaviour Support to reduce or eliminate the use of restrictive practices. Important, salient aspects of the research literature regarding positive behaviour support are evident in the legislation. Whilst the relationships between these aspects of the legislation and the research literature may not be immediately apparent to those who have not previously studied Positive Behaviour Support, they are relatively clear to students of the discipline. Some of these have been evidenced as the most critical approaches to achieving positive behaviour change. By way of example, the following requirements of Queensland's Disability Services Act relate specifically to the research evidence on the most critical elements of positive behaviour support:

a) Assessment of causal features (s.148[3]b);

b) Teaching skills (s.150[1]b);[5]

c) A focus on quality of life (s.150[1]c);

d) Reducing intensity, frequency and duration of challenging behaviour (s.150[1]d);

e) Consideration of consequence (s.150[2]a)[6];

f) Early warning signs and triggers (s.150[2]a).

[5] The PBS literature notes that skills teaching should focus on assisting the person with a disability to find alternative ways to meet their needs, in replacement of the challenging behaviour.

[6] The term 'consequence' has a very specific meaning in the assessment phase of Positive Behaviour Support and describes the principal intent of challenging behaviour. This in turn, directly informs the skills to be taught (see footnote 5)

16 In 2016, a review of the quality of positive behaviour support in plans in use in Queensland was published by the Journal of Intellectual and Developmental Disability[7]. This research was led by myself, in partnership with colleagues at the Queensland Centre of Excellence for Behaviour Support. This work focussed on the adherence of the Queensland legislation and practice to the scientific evidence on the support of people with disability and challenging behaviour. The research did not consider its specific impact on or outcomes for people with disability. The findings of this paper support Multicap's view on the regulatory framework as it applies in Queensland, namely that:

a. 'Black Letter' application of the legislation risks Positive Behaviour Support plans being written in such a way that front line, operational staff are unable to interpret and/or successfully implement them;

b. Regulatory approval of Positive Behaviour Support plans should include a clinical evaluation of their likely efficacy; and

c. Many Positive Behaviour Support Plans are approved, despite displaying poor adherence to the clinical aspects of the discipline.

17 I am unaware of any systematic review that would assist in determining whether the regulatory reforms have delivered on the above legislation's objective to reduce and eliminate the use of restrictive practices nor the goal of positive behaviour support to reduce the impact of challenging behaviour on people's lives. Despite this, data has been provided to various regulatory bodies for a number of years that could be used to respond to these questions. Overall reductions in challenging behaviour could be measured by aggregating behavioural trend data which is submitted annually to Guardians in Positive Behaviour Support Plans. Reductions in overall rates of Restrictive Practices could be drawn from the same source or in the annual appointments of Restrictive Practice Guardians by the Queensland Civil and Administrative

[7] Wardale, S., Davis, F., Vassos, M., & Nankervis, K. (2016). The outcome of a state-wide audit of the quality of positive behaviour support plans. *Journal of Intellectual and Developmental Disability, 43, 2,* 202-212.

Tribunal. Data on organisational use of Restrictive Practices has been submitted monthly to the Queensland State Government since 2015 as required by legislation and would similarly show trends in Restrictive Practice use. With such a substantial data set at hand, it is disappointing that large scale reviews of the reforms prompted by Justice Carter have not been routinely or sequentially undertaken. Such investigation would provide advice to the disability sector on the efficacy of its endeavours, and substantial information to both levels of government on the benefits associated with its investment. I am aware of similar data held in Victoria and an analysis across jurisdictions would further inform and enhance the next generation of reforms, currently being undertaken at a national level.

18 I am aware that some colleagues in other organisations have expressed confusion regarding the intersection of Queensland and federal regulation, particularly where definitions and requirements appear to differ. Although there are differences in the definitions and scope of the state and federal regulations regarding restrictive practice, I do not consider that they differ to an extent that impedes policy implementation or good practice. In some instances, the changes have facilitated improved opportunities for people with a disability.

Behaviour support and the use of restrictive practices

19 Approximately 10% of Multicap's total customers receive targeted behaviour support, and have involvement from a behaviour support clinician. This figure approaches 40% when considering customers who access our supported and independent accommodation services. These ratios are broadly consistent with

overseas research on the prevalence of challenging behaviour in people with intellectual disability.[8] [9]

20 It is important to distinguish Multicap customers who receive behaviour support from those who are additionally subject to restrictive practices. It is Multicap's position that the presence of behaviour that may cause harm to self and others should be the threshold for access to specialised services, not solely the use of restrictive practices. In many cases, even where challenging behaviour is present, good quality behaviour support can both reduce the risk of harm and eliminate the need for restrictive practices. As such only half of those Multicap customers who receive behaviour support require the additional use of restrictive practices.

21 The behaviour support team leads Multicap's capability development and has a targeted approach to induction, training and peer support of clinical staff. An initial program of development for new clinicians targets the key clinical skills and knowledge identified in the Positive Behaviour Support literature, and in particular, those that are not routinely included in most academic programs. This includes principles of behaviour change, data interpretation, technical approaches to behavioural assessment, and teaching alternative (non-harmful) behaviours to people with a disability. This stage is followed by 40 hours of competency based training endorsed by the Behavior (sic) Analyst Certification Board (BACB). The BACB is an international registering body that sets standards for education and practice in behaviour analysis. This is a similar approach to that taken by the Australian Psychological Society or Speech Pathology Australia, whereby credentialing bodies establish standards of

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[8] Emerson, E. (2001). *Challenging Behaviour: Analysis and intervention in people with severe intellectual disabilities*. London: Cambridge University Press

[9] Poppes, P., van der Putten, A.J.J., & Vlaskamp, C. (2010). *Frequency and severity of challenging behaviour in people with profound intellectual and multiple disabilities*. Research in Developmental Disabilities, 31, 1629-1275.

academic course content, allowing both registration of the training body and its subsequent graduates

22 Whilst undertaking the training outlined above, new clinicians also undertake internal training on effectively using one of the most common tools recommended to determine the likely efficacy of a Positive Behaviour Support Plan[10]. In combination, these initial stages of induction training typically lasts approximately three months.

21. Upon completion of Multicap's induction program for clinicians, the behaviour support team participate in on going, monthly case reviews where customer plans and progress are discussed. These case reviews are chaired by the Manager of Behaviour Support Practice, who mentors clinicians to share ideas, problem solve, and collaborate with each other in determining the best approach to improving outcomes for individual customers. In this process, clinicians accept a strict commitment to act on agreed improvements, and report back to their team on progress.

22. Whilst Multicap's' clinical team is responsible for leading behaviour support practice, all operational front line staff have a potential role in the support of people with challenging behaviour. Accordingly, all operational front line staff employed at Multicap are trained in basic behavioural interventions at induction. This includes understanding behaviour, responding to escalating agitation, diffusion and calming techniques, as well as reporting requirements.

23. Where front line staff are responsible for the support of a person who uses challenging behaviour, training is provided by the clinical team both in behavioural theory, and its application to the individual customer in question. This necessarily includes the content of the Positive Behaviour Support Plan, its effective implementation, requirements of any specific restrictive practice, and

[10] Browning-Wright, D., Mayer, G. R., & Saren, D. (2007). *The behavior support plan quality evaluation guide – Version II.* Retrieved from http://www.pent.ca.gov

the approach to ongoing collaboration between customer, operational team, clinical team and external stakeholders. This highly personalised approach is essential. Both theory and practice based knowledge is evaluated, and informs future supports provided by the clinician to the team. This follow up is undertaken in situ, as clinical and operational staff collaborate and 'trouble shoot' customer support. The intent is to determine deficits in either Positive Behaviour Support Plan design, or implementation, in a collegial and positive manner. It also serves to ensure that learning occurs across both clinicians and front line staff, in a manner that is both practical and extends well beyond any single training activity.

24. Managers responsible for supervising front line staff continue their development via brief, monthly training activities on a range of topics relating to good practice in supporting people with complex needs, thus building their capability in supporting front line staff. These sessions are delivered by the clinical team and again, are subject to formal evaluation.

25. At an organisational level, Multicap's documented response to challenging behaviour has four levels of increasing sophistication. These four levels create a structured response for all Multicap's customers, regardless of their complexity.

26. Level One is a routine and annual (or during customer on boarding) survey of individual customer behavioural patterns to determine if previously unidentified need has emerged in any particular customer.

27. Level Two is the approach ordinarily funded by the National Disability Insurance Agency (**NDIA**) or required by state and federal restrictive practice regulation. At Level Two, customers with specific behavioural needs are identified, a behaviour support clinician is allocated, Positive Behaviour Support Plan prepared and close collaboration between clinical and operational services occurs to ensure the delivery of evidence based support.

28. Level Three is a joint initiative between clinical, operational and human resource functions. Multicap Senior Managers (General Manager Level and above) meet monthly to systematically review emergent risks across the organisation. The meeting reviews incident report trends, customer complaints, and tenancy issues to monitor emerging or potential risks to Multicap customers and as a consequence staff. Where unreasonably high (or inexplicably low) incident reporting is identified, clear actions are set to investigate and or remediate the circumstances influencing the data.

29. Level Four is a joint initiative between myself, the Chief Operating Officer and Chief Employee Experience Officer. A full day per month is allocated to consider the support needs, data, and progress, pertaining to Multicap's most complex of customers. This complexity is ordinarily identified via the Level Three process outlined above, and is defined by very common (i.e. greater than ten incidents per month) or very serious incidents. Senior operational managers, behaviour support clinicians and health and safety managers attend, to report on and consider all aspects of these customers' support. The meeting spends an average of 30 minutes reviewing each customer's progress. Level Four seeks to support both customers and their supporters, by dedicating the most senior personnel in the organisation to an extended and collaborative problem solving activity. The discussions are data led, with a commitment to longitudinal and demonstrable improvement in customer outcome. Clear actions are determined and high levels of accountability maintained in the execution of agreed responses.

30. A variation to the Level Four activity is available where significant and unforeseen behavioural escalations may occur. 'Emergency Forums' are convened, with a commitment that all available personnel attend at a minimum of four hours' notice. It is Multicap's expectation and practice that 'Emergency Forums' are treated with the highest possible priority, and all but the most critical work tasks be postponed to support the convening of the forum. As with

previously described Multicap processes, these seek to provide real time problem solving from multiple functional areas of our organisation. The intent is that customers have access to the highest levels of expertise from across functional areas, substantially reducing the risk that any given crisis becomes irretrievable.

31. One recent and successful example of a Level Four emergency response relates to a female person supported by Multicap who was subject to domestic violence by her partner. Following a deterioration in her relationship, she had engaged in serious attempts at self-injury and was left homeless. During the provision of an immediate safe support response for this person, her partner also assaulted several Multicap staff. The Level Four response included close collaboration with the police, local hospitals, mental health services, Public Guardian, and Multicap's clinical, operational, human resource and work, health and safety functions. In the following period, her living arrangements and support was stabilised and she was assisted to develop some basic skills in navigating her relationship. After several months, she was able to exit the crisis accommodation support provided to her by Multicap and enter a long term accommodation and support arrangement.

32. Multicap is both proud of, and confident in, its ongoing and strategic response to people with complex needs. This is defined by attention to advanced clinical skills, timely and data driven responding and integration between multiple functions of the organisation. This does however present some challenges when supporting customers who exercise their right to choose an external clinical (behaviour support) provider. This typically occurs where a customer or their representative engages a third party clinical provider directly, via the use of their NDIS funds. In these situations, Multicap may not be aware of the capability of the clinician, or the organisational approach to their training and development. Multicap is also unable to direct the activity of these clinicians, risking poor clinical response, ill-considered behavioural interventions and poor collaboration

between the clinician and Multicap personnel. This lack of a unified approach has presented a real and significant risk to customer safety. An example relates to a customer who came to Multicap as a result of their prior service provider being unable to meet their needs. The customer and their representative chose a third party behaviour support provider, who ultimately changed the clinician allocated to this customer on three different occasions. In over six months, a Positive Behaviour Support Plan was never provided, the clinician failed to train Multicap staff in individualised responses, and the customer continued to engage in high levels of self-injury resulting in repeated trauma to the customer's head. Multicap intervened with the integrated response outlined previously in this document, despite the funding for the support being directed to the third party. The structure of the NDIS funding regime does not explicitly provide a sensible way forward in these situations.

33. The above outlines the variability between Multicap's integrated response to complexity, and a funding model that empowers the customer to directly engage multiple providers. In some situations, typically where there is significant complexity, the customer has little understanding of clinical processes and is poorly positioned to interrogate that capacity of their clinical service provider. Similarly, that provider has no imperative to acquiesce with Multicap's embedded and integrated processes. As a result, we are increasingly advocating that behaviour support funding be allocated to Multicap's clinical team where we have already been engaged by the customer for the provision of other services. We are of the view this is within the scope of NDIA requirements, however acknowledge the tensions between this approach and the true exercise of choice and control.

34. Notwithstanding access to behaviour support funding, the direct, individual customer and transactional unit price model that the NDIS is built on, makes delivery of holistic integrated approach to support for people with complex behaviours very difficult. Further, some pricing structures such as those

associated with high intensity support do not incentivise reductions in challenging behaviour, fundamentally risking the structures that facilitated such positive customer outcomes. By way of example, 'high intensity funding' for operational support of a person with complex behaviour, requires that at least one behavioural incident occurs per shift. However the continuation of such high frequency of challenging behaviour would demonstrate failures on multiple levels. By way of contrast, Multicap's current response is to dedicate support across multiple functional areas, to ensure that such high rates of challenging behaviour do not occur. This response occurs as a result of significant organisational investment. Perversely, the effect of this investment is to restrict Multicap's ability to access this higher rate of NDIS funding.

35. In addition to the development of staff and organisational capability to respond to challenging behaviour, Multicap has an interest in the role specialised built environment design can have in delivering improved outcomes for customers who have complex needs. Two distinct projects have been undertaken recently by Multicap, in collaboration with the Queensland University of Technology design school, to integrate improved models of support with advanced design of the built environment. One such project resulted in a unique purpose-built building used to respond to people in crisis and at short notice. The building was designed with a transitional customer group in mind. As such, it required functionality for a broad range of customer needs and the flexibility to initiate or cease use of particular design features episodically. General features include a very robust design that was highly tolerant to abuse. A flexible range of accommodation options are possible within the building allowing individualised responses for people requiring this crisis accommodation. Easy cleaning was a requirement, given the potential for spill of body fluids or waste. In delivering these aspects, the house needed to blend with surrounding buildings and support access to community amenity. Internally, ligature points were designed out, utilities were placed on several different circuits allowing parts of the building to be isolated as needed, and open spaces were created for both ease of

visibility, and to facilitate rapid movement of both staff and customers including access and egress. In providing such, customer privacy could not be compromised and access to personal and private space maximised. The kitchen can be fully secured to manage risk however a fully retractable shutter is in place to reduce the appearance of security. Outdoor and alfresco areas have been visually enhanced to encourage use whilst maintaining a secure environment, and therefore decreasing time in close contact with others while indoors.

36. This building was highly commended in the HIA Housing Awards. A second house is currently in the final stages of design and will target the needs of people with Prader Willi syndrome, a relatively rare condition with a known behavioural phenotype.

37. These projects further reflect Multicap's established position that people with the most complex of needs require an integrated response, across organisational functions. In addition to the clinical, operational and human resources responses detailed elsewhere, the purpose built houses draw upon the expertise of Multicap's property and facilities department to ensure the practical delivery of design concepts.

38. Multicap's clinicians experience a lack of medical practitioners skilled in support of people with behaviours of concern. In my experience, it is not uncommon to encounter medical practitioners entirely unfamiliar with the alternatives to restrictive practice (in particular chemical restraint), such as positive behaviour support. Multicap would support the development of tools and resources to the medical fraternity, which would assist doctors in identifying effective and non-restrictive behavioural responses potentially in place of prescribing medication. This, combined with an extension of regulatory scope to the prescriber, would ensure the consideration of evidence based alternatives, prior use of any chemical restraint. The disability sector has made significant improvements in practice on the back of regulation, and we are of the opinion that extending the scope of regulation to medical practitioners, would be similarly beneficial.

Suggestions for further reform

39. It is my and Multicap's position that the next generation of reform should respond to the practical realities of operational disability service provision. Such consideration would focus upon:

a. Application of the legislation, including approvals provided by regulatory authorities, occur with an understanding of the research evidence base;

b. The audience and 'end user' of positive behaviour support plans be acknowledged as front line disability support staff. This cohort of professionals are typically untrained or have vocational training only. Increasingly many are from non-English speaking backgrounds. Positive behaviour support plans that demonstrate lengthy references to legislation, or that have been written with a focus on statutory approval, are an impractical tool for these ultimate users of the plan and result in poor outcomes for individuals being supported;

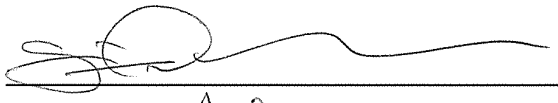
c. Funding should maximize the clinicians' availability to work alongside staff to train and review the success of agreed strategies in real time with the outcomes being a more timely and tailored response for each individual person. Similarly, the reporting obligations of clinicians to both regulatory and funding bodies, should explicitly seek to consider the quality and quantity of in situ mentoring of customer representatives including families and carers.

d. The developers of positive behaviour support plans should be responsible for the outcomes of the people with disability who are subject to such plans. Where outcomes are not evident, escalating levels of scrutiny should be applied.

Conclusion

40. Multicap has a long and proud history of supporting people with complex needs. We are of the view that practice standards improve when organisations undertake a specific overarching strategy to ensure this occurs. The approach to regulating restrictive practices does not interfere with this whole of organisation approach, and previous policy initiatives have clearly prompted and ensured improved service responses. To this stage however, regulatory reform has sought broad and generalised improvement, not necessarily supported high level and sophisticated organisational development.

41. Multicap looks forward to future initiatives and reforms that recognise behaviour support as a specialist, 'whole of organisation' initiative, and are based on a detailed understanding of the front line support context and applied integration of clinical and operational practice.

Signed: 

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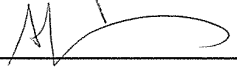
Witness: 

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