



**SUBMISSION BY NADD ONTARIO**  
**February 16, 2010**

**The Draft Minister's Regulation on Quality Assurance  
Measures**

**The Services and Supports to Promote the Social Inclusion of  
Persons with Developmental Disabilities Act, 2008**

## SUMMARY OF RECOMMENDATIONS

1. The Bill 77 Regulations include a pre-amble that highlights the underlying fundamental principles and context of the regulations to support **services and supports to promote the social inclusion of persons with developmental disabilities.**
2. The pre-amble include the requirement to abide by the Personal Health Information Protection Act, the Health Care Consent Act and the Substitute Decisions Act.
3. An arms length provincial advocate's office be established with the mandate of receiving and investigating complaints related to adults living with developmental disabilities and dual diagnosis, including possible rights violations and other complaints that may arise regarding the application, assessment and re-assessment process under the provisions of Bill 77.
4. The Ministry of Community and Social Services establish a policy directive regarding Behaviour Intervention Safeguards.
5. The Quality Assurance Regulations be rewritten to describe general parameters of quality rather than specific activities.
6. Part III of the Quality Assurance Regulations be rewritten more broadly referring to the requirements for:
  - Functional assessments, use of informed and/or best practices by persons with training and with the appropriate monitoring of, and feedback to staff on intervention integrity by supervisors trained to do so
  - Transfer Payment Agency staff to receive the necessary training to demonstrate appropriate use of techniques
  - Procedures for ensuring the safety and rights of individuals
  - Mechanisms for ethical review
7. A self regulating body for behaviour interventions, such as through the existing Ontario Association for Behaviour Analysis, be considered.
8. The term "behaviour support plan" be replaced throughout the regulations with **person centred multimodal support plan based on biopsychosocial principles.**
9. Further to recommendations 1 and 2, the pre-amble include reference to biopsychosocial principles underpinning informed and/or best practice in the field.
10. NADD Ontario recommends that the Entity application form and needs assessment form are acknowledged to be the minimum base of back ground material required for an individual support plan. Previous discharge summaries from hospitalizations, psychological, psychiatric, occupational therapy, speech and language assessments, medical, and including neurological and genetic assessments, for example, all may contain information critical to developing a support plan for an individual with developmental disabilities.

11. Agencies shall have policies and procedures regarding financial capacity assessments when a person's ability to manage their day-to-day finances is in question and an SDM has not been identified.
12. MCSS reinstitute training of capacity assessors.
13. Provisions for funding assessments under item 11 be established.
14. The individual's capacity to make decisions with regard to finances, personal care and the procedure for obtaining treatment consent is documented in the Individual Support Plan.
15. A definition of 'health' is added to the regulations as follows: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."  
(WHO, [www.who.int/suggestion/faq/en/](http://www.who.int/suggestion/faq/en/), accessed Feb, 2009)
16. Remove reference to "healthy lifestyles" in the document
17. Staff document visits for medical services when they occur by the individual independently or with a significant other, and include any results reported to them by the client and/or significant other
18. The wording of **7.(1) 3** be revised as follows: "Standards, policies and procedures for the...where a staff member is administering or providing assistance to..."
19. The wording of **7.(1) 3-ii** be revised as follows: "safe and effective administration (including self administration), of medication..."
20. Add an additional bullet under **7.(1) 3-v** as follows: "Regular review and monitoring of all medications by a qualified health care practitioner."
21. Add an additional bullet under **7.(1)3-vi** as follows: "Consent to treatment."
23. Add an additional bullet under **7.(1)3-vii** as follows: "Annual training by a qualified health care practitioner on medication administration to all staff administering or assisting in the administration of medications.
24. The family or SDM of clients incapable of consenting for themselves shall be notified within 24 hours after the service agency becomes aware of an alleged, suspected or witnessed incident of abuse of a person with a developmental disability.
25. The service provider shall follow the expressed preference of the individual with a developmental disability who is capable of consent with regard to the notification of family or significant others after the service agency becomes aware of an alleged, suspected or witnessed incident of abuse of a person with a developmental disability.
26. The service provider shall advise the family or SDM when corrective action has been taken, within the context of the consent as per 24 and 25.
27. As per Recommendations 2, above.
28. The service shall also include copies of materials that support continuity of care and provide a comprehensive understanding of a persons needs including:
  - crisis support plans,
  - discharge summaries from hospitalizations,

- multi-disciplinary assessments previously provided, such as psychological, OT, speech & language, psychiatric, behavioural, neurological, genetic assessments
29. As per Recommendations 8.
  30. Remove and replace as per Recommendations 4, 5, 6 and 7.
  31. Remove 'prescribed medication to control behaviour' from the definition of intrusive behaviour intervention, as per Recommendations 4, 5, 6 and 7.
  32. The Ministry undertakes to establish an expert panel to develop a Policy Directive regarding standards and guidelines for the administering of medication applicable to the Ontario context.
  33. As per Recommendations 4, 5, 6, 7 and 8.
  34. As per Recommendations 4, 5, 6, 7 and 8.
  35. As per Recommendations 4, 5, 6, 7 and 8
  36. Staff document in the service record the process for involvement and input by the person with a developmental disability and their family/significant other in the development of person centred plans. This would also include signature of the person with a developmental disability and /or family/significant others for those unable to provide informed consent.
  37. As per Recommendation 31.
  38. The Ministry, in consultation with experts in the field, establish formal plans to address the interim gap regarding psychology sign off in order to achieve the requirements of Regulation 18 (4) (f).
  39. The Ministry, in consultation with experts in the field, establish a human resource 10 year plan to address the gap in psychology and psychology associates required to achieve the requirements of Regulation 18 (4) (f).
  40. Notwithstanding the above, we reiterate Recommendations 4, 5, 6, 7 and 8.
  41. Regular monitoring be defined as every 15 minutes at a minimum with appropriate documentation in the service record.
  42. The family or SDM should be informed, within 24 hours of when an intrusive intervention has been implemented, and within the context of the appropriate consents.
  43. Notwithstanding the above we reiterate Recommendations 4, 5, 6, 7 and 8.
  44. As per Recommendation 14.
  45. Regulation 23 (1) be reworded as follows:  
Assistance is provided to the person *to attend regular health appointments as recommended in the Ontario Primary Care Guidelines ( Sullivan , In press 2009)* and that a log is kept or documentation is kept on file with respect to the person's regular *health care* appointments.
  46. As per Recommendation 28.

## **I INTRODUCTION**

This submission is made on behalf of the National Association for the Dually Diagnosed – Ontario Chapter (NADD Ontario) in consultation with its provincial membership.

NADD Ontario is a voluntary provincial association representing families and service providers who work in the health and developmental service sectors. We are concerned about the mental health of individuals with developmental disabilities. Our advocacy activities focus on service excellence through initiatives that support education and training directed to staff and families.

### **NADD Ontario Mission:**

To advance mental wellness for persons with developmental disabilities through the promotion of excellence in mental health care.

### **NADD Ontario Vision:**

We envision a society wherein persons with a developmental disability and mental health needs (dual diagnosis) and their families have full and equitable access to supports and services that promote and enhance their mental health and well-being.

We believe that this can be achieved through:

- a continuum of supports and services that includes family and natural supports and ranges from the promotion of mental health to treatment and long term care.
- integrated and collaborative approaches to services and supports
- treatment approaches that are based in biopsychosocial models of care

The current strategic focus of NADD Ontario's efforts include:

- ***Lobbying and advocacy*** at the provincial and national levels to ensure public policy includes provisions for people with dual diagnosis and their families
- ***Development of a capable workforce*** through coordinated and sustained clinical education/training paths with articulated competencies.
- ***Human services are created*** and accommodations occur to integrate people with dual diagnosis
- ***Families and individuals have the necessary information*** to make informed decisions
- ***NADD Ontario is recognized*** as a “go to” place for information and advice about dual diagnosis

***Dual diagnosis in Ontario refers to people who have both a developmental disability and mental health needs.*** In Ontario, **38%** of individuals with a developmental disability

have a dual diagnosis.<sup>1</sup> In terms of actual numbers, this means that, out of 304,007 Ontarians with a developmental disability, **115,522** have a dual diagnosis.<sup>2</sup>

This submission is focused on the *implications for people with dual diagnosis of the* Draft Ontario Regulation Quality Assurance Measures under Bill 77. In preparing this response NADD Ontario consulted its 100 + members through e-mail. We are also very pleased to report that a Video Conference consultation occurred on February 4<sup>th</sup> that included twelve sites with approximately 40-50 participants.

## II GENERAL COMMENTS

We commend the intent of Bill 77 to improve the services and supports for adults who have developmental disabilities and their families. The Quality Assurance Measures Regulation is an ambitious endeavour to address key areas to improve safety, choice, services, and accountability in the developmental sector. These are important areas that persons with developmental disabilities, families and service providers have had concerns about for some time. However we find that some of the regulations will in fact contribute to further confusion in practice because they cross over and contradict existing regulations and regulated disciplines, including for example, the Regulated Health Professions Act, Health Care Consent Act, and Substitute Decisions Act. Additionally, some of the regulations are particularly prescriptive and contradict each other, thus causing further confusion.

Broadly, NADD Ontario's comments and recommendations arise within the context of:

- 1) Consent and the rights of individuals with developmental disabilities,
- 2) The implications of using a regulatory framework with incomplete detail thus resulting in misinterpretation rather than clear policy directives to guide best practice principles
- 3) Behaviour support plans that, other than reference in Part III 18(3), do not appropriately reflect the developments in the field regarding the person centred, multi-modal approach based on biopsychosocial principles.

In essence, we believe that the Regulations, in an effort to address a number of important areas, in the end confuse and complicate achievement of the intended goal. There are other means available to government that are referenced in this response to address the more detailed aspects of quality of care. **NADD Ontario submits that the Regulations would be more effective and enforceable by describing general parameters of quality rather than specific activities.**

We will address these 3 issues first followed by a review of the specific Regulations.

### Issue 1. Consent and the rights of individuals with developmental disabilities

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<sup>1</sup> Yu, D. & Atkinson, L. (1993, republished in 2006). Developmental disability with and without psychiatric involvement: prevalence estimates for Ontario. *Journal on Developmental Disabilities*, Spring, p. 1 – 6

<sup>2</sup> Ibid

NADD Ontario previously submitted a recommendation regarding Bill 77 that stated:

Throughout its provisions, where relevant, Bill 77 must reference the Personal Health Information Protection Act, the Health Care Consent Act and the Substitute Decisions Act and align itself with these Acts.

This reference has now been included in Regulations 10 and 31 in a broad way, however is buried and as such becomes lost as part of an underlying principle of quality of care.

Further, common law assumes in the first instance the capacity of individuals to consent. However the Regulations as they are worded do not. In many instances individuals with developmental disabilities or dual diagnosis continue to live with or be supported by families. Often the family will assume that their son or daughter requires a Substitute Decision Maker and providers will comply. For the most part this may not be problematic and the best practice would be for the provider to engage both the individual and family in the consent process.

However there are instances where the presumptions concerning an individual's care and decision making result in the denial of their rights and vulnerability to abuse. This can have significantly negative consequences for example in relation to the management of finances and particularly in relation to abuse concerns.

Service providers must operate under the full understanding of the laws of the land and have the appropriate processes in place to access capacity assessors when required in order to be able to adhere to these individual rights, the intent of Bill 77, existing legislation and best practices.

Similarly there continues to be no recourse within the Regulations if an individual feels that his or her rights are violated as a result of a decision by the Application Entity. In a previous submission regarding Bill 77 NADD Ontario recommended:

An arms length provincial advocate's office be established with the mandate of receiving and investigating complaints related to adults living with developmental disabilities and dual diagnosis, including possible rights violations and other complaints that may arise regarding the application, assessment and re-assessment process under the provisions of Bill 77.

We reiterate this recommendation below. It is also noteworthy that previous submissions by ARCH: *A Legal Resource Centre for Persons with Disabilities* outlined similar concerns and provided similar recommendations. (Response to the MCSS Discussion Paper Transforming Service in Ontario for People who a Developmental Disability, December 14, 2004 and ARCH submission re: Bill 77 presented to the Standing Committee on Social Policy dated August 12, 2008)

***Recommendations:***

1. The Bill 77 Regulations include a pre-ambble that highlights the underlying fundamental principles and context of the regulations to support **services and supports to promote the social inclusion of persons with developmental disabilities**.
2. The pre-ambble include the requirement to abide by the Personal Health Information Protection Act, the Health Care Consent Act and the Substitute Decisions Act.
3. An arms length provincial advocate's office be established with the mandate of receiving and investigating complaints related to adults living with developmental disabilities and dual diagnosis, including possible rights violations and other complaints that may arise regarding the application, assessment and re-assessment process under the provisions of Bill 77

## **Issue 2. The use of a regulatory framework vs. policy directives and existing professional bodies to guide Best Practice principles**

This issue is most apparent within Part III of the Regulations regarding Behaviour Intervention Strategies. From the cross-sectoral perspective of the NADD Ontario membership, it appears that the Quality Assurance Measures are an attempt to legislate behavioural standards for those working within the developmental sector. While we applaud the recognition that a regulatory framework is important and necessary in developmental as well as intervention services, we question the advisability of achieving this accountability through Regulation instead of through Policy Directives for Bill 77. A key reason for this arises from the principle of evidenced-based research, which progresses knowledge in the field and informs best practice, and by its' very nature, implies revision in and incorporation of new knowledge over time.

To regulate support approaches through Ontario Regulation for Quality Assurance Measures runs the risk of losing quality of practice and accountability, which professional disciplines are better structured and regulated to oversee. Permit us an analogy to demonstrate this point: envision if Ministry of Health and Long Term Care legislation included regulations governing the prescription of medication. Frequent changes would need to be signed off by Cabinet, and effective monitoring / accountability mechanisms would be costly if not impossible, whereas the College of Physicians and Surgeons is structured to meet the mandate of quality assurance based on current research, development, and has mechanisms for oversight. Members of the noted College are obligated to these Quality Assurance processes. In summary we are of the strong opinion that it is not only inappropriate but also not within a government ministry's expertise to be legislating how services are to be provided at the level of the individual practitioner.

NADD Ontario also believes that the recommendations of the Expert Panel on Behaviour Intervention Safeguards would be more accurately represented through a Policy Directive. The Policy Directive would require the implementation of the Panel's Behavioural Standards, rather than what appears to occur in a piecemeal and prescriptive

fashion in the Regulation. The current document results in incomplete and misleading representation of the recommendations of the Expert Panel. Overwhelming feedback from our membership suggests that agencies and families would welcome new behavioural standards arising from the Expert Panel's well researched recommendations.

On a related issue, by its' very nature, 'challenging behaviour' is often symptomatic of underlying medical, psychiatric or mental health issues, or associated with a syndrome-related behavioural phenotype, requiring a multidisciplinary team of providers working together to effect positive change to support community participation. This team can include the Transfer Payment Agency staff along with other specialties from outside the sector (e.g. physicians, nurses, psychologists, occupational therapists, physiotherapists, speech language pathologists, etc.). Certain of the interventions that may be required to address the challenging behaviour/disorder are regulated or even controlled acts in other legislation (e.g., diagnosis, delivery of prescribed medication or the use of least restraint procedures). These currently existing legislation can regulate procedures and at a minimum serve to inform practices within the sector. As per Issue 1 above, the Ministry of Community and Social Services would be in the best position by situating the services provided by its Transfer Payment Agencies within the existing legislation and regulations, rather than attempt to create its own or recreate what already exists. Proceeding down the pathway of integrating with the existing professional colleges and regulatory bodies to recognize this population (developmental disabilities) and more importantly, those with dual diagnosis, creates an opportunity to facilitate more integrated approaches where currently there exist barriers and gaps in understanding and effective collaboration.

There are also ongoing efforts to develop a self-regulatory body for behavioural supports (e.g., Ontario Association for Behaviour Analysis) where standards of practice have already been established. Deferring to a group with expertise and knowledge similar to other regulatory bodies will support the quality assurance, risk reduction, and oversight of behavioural approaches that is a goal of the legislation.

In summary, rather than the prescriptive detail in the current draft Regulation, which includes regulation of specific behavioural techniques, the intent of the Regulations would be more effectively and appropriately enforceable by describing general parameters. For example, rather than describing or defining a specific technique (e.g., time out, physical restraint) the Regulation would state that the technique be determined through a functional assessment and informed and/or best practice, by someone with the appropriate/credentialed training and/or clinical supervision, that support staff are trained by appropriately regulated professionals and demonstrate competence in the appropriate use of the technique, that the safety and rights of the individual are underlying principles, and that there is a mechanism for ethical review.

***Recommendations:***

4. The Ministry of Community and Social Services establish a policy directive regarding Behaviour Intervention Safeguards.

5. The Quality Assurance Regulations be rewritten to describe general parameters of quality rather than specific activities.
6. Part III of the Quality Assurance Regulations be rewritten more broadly referring to the requirements for:
  - Functional assessments, use of informed and/or best practices by persons with training and with the appropriate monitoring of, and feedback to staff on, intervention integrity by supervisors trained to do so.
  - Transfer Payment Agency staff to receive the necessary training to demonstrate appropriate use of techniques
  - Procedures for ensuring the safety and rights of individuals
  - Mechanisms for ethical review
7. A self regulating body for behaviour interventions, such as through the existing Ontario Association for Behaviour Analysis, be considered.

**Issue 3. Behaviour support plans do not appropriately reflect the developments in the field regarding the person centred, multi-modal approach based on biopsychosocial principles**

In attempting to address risk concerns by regulating professional practice within the framework of a regulatory document, Part III actually conveys a very narrow and limited understanding of best practices related to responding to ‘challenging behaviour’. Paradoxically, this in fact will increase the risk for individuals receiving care. The wording appears reactive and based in ‘old school behaviour management’ practices reminiscent of the 1970’s rather than embracing current best practice. For example, to define a ‘behaviour support plan’ as behaviour interventions ‘designed to change the behaviour of another person’ places the onus for the behaviour on the individual with a developmental disability, rather than understanding behaviour as a means of individual communication of, for example, physical or emotional pain, or environments that are at odds with their physical or mental health needs.

The term ‘**behaviour support plan**’ is also contradictory and incongruent with the current practice of holistic care through a multidisciplinary approach. The reference under Regulation 18(3) that the behaviour support plan is based on assessment ‘that considers biological, medical, historical, emotional, psychological and environmental factors, as well as the social and cultural context of the person’ is much more congruent with current thinking and practice. However this is lost in the remainder of the document. Additionally many individuals with developmental disabilities will experience challenging behaviour (e.g., as expressed through self injurious behaviour, aggression or destruction of property). At times there may be a need to address such behaviours to protect the safety of the individual or others. It is therefore important for the Regulations to note that such interventions are developed as one component of an **integrated multi-**

**disciplinary / person centred multi-modal support plan based on biopsychosocial principles.**

***Recommendations:***

8. The term “behaviour support plan” be replaced throughout the regulations with **person-centred multimodal support plan based on biopsychosocial principles**
9. Further to recommendations 1 and 2, the pre-amble include reference to biopsychosocial principles underpinning informed and/or best practice in the field.

### **III SPECIFIC RECOMMENDATIONS**

**Part II General  
Development of individual support plans**

**Section 5(3):** The service agency shall base the individual support plan on information contained in the application form and the needs assessment used by the application entity and the plan shall identify:...

As the intent of the legislation is to focus on services and supports to promote social inclusion this principle must guide all aspects of the regulations. The Application Entity application form and needs assessment may provide an overall summary of an individual and his or her life needs, but it may not be complete enough to promote social inclusion or a thorough individual support plan if it does not also include available multi-disciplinary input. For example, currently 3<sup>rd</sup> party planning reports often do not incorporate adequate clinical history and information. For this reason we suggest that additional relevant material from previous individualized plans, information from health and mental health and school reports will provide a more thorough and accurate picture over time of an individual’s needs.

***Recommendation:***

10. NADD Ontario recommends that the Entity application form and needs assessment form are acknowledged to be the minimum base of background material required for an individual support plan. Previous discharge summaries from hospitalizations, psychological, psychiatric, occupational therapy, speech and language assessments, medical, and including neurological and genetic assessments, for example, all may contain information critical to developing a support plan for an individual with developmental disabilities.

**Part II General**  
**Management of and assistance with finances**

**Section 6(1):** Each service agency shall have policies and procedures regarding the management of and assistance with finances for a person with a developmental disability who receives services and supports from the agency, where the person requires assistance with management of their day-to-day finances.

The reference to ‘assistance with management’ is somewhat vague when applied at the front line. Our members continue to receive reports of staff supporting persons with developmental disabilities to manage their finances by assisting them to make their “mark” on bank documents. This practice promotes exploitation. Examples also exist where a person with a developmental disability may understand the concepts associated with managing his or her finances, but is *presumed* to require assistance, and thus denied a basic right. In either circumstance the individual with developmental disabilities does not have adequate recourse to protect their rights, equivalent to other members of society.

The cost of a capacity assessment is also not covered unless the person with the developmental disability requests it. This is limiting for the provider that has concerns but not the adequate funds, and also leaves the person in a continuing vulnerable circumstance.

Additionally, the Individual Support Plan should document the person’s capacity and all subsequent decisions need to be informed and implemented based on this finding.

Therefore, in addition to Recommendation 2 above:

***Recommendations:***

11. Agencies shall have policies and procedures regarding financial capacity assessments when a person’s ability to manage their day-to-day finances is in question and an SDM has not been identified.
12. MCSS reinstitute training of capacity assessors.
13. Provisions for funding assessments under item 11 are established.
14. The individual’s capacity to make decisions with regard to finances, personal care and the procedure for obtaining treatment consent is documented in the Individual Support Plan.

## **Part II General**

### **Health promotion, medical services and medication**

**7. (1)** In addressing quality assurance measures respecting health promotion, medical services and medication, each service agency shall have the following:

- 1.** Policies and procedures respecting the provision of information on health promotion and health lifestyles ....
- 2.** Policies and procedures to monitor the health concerns of the persons with developmental disabilities who are receiving services and supports from the agency.

The reference to health promotion, medical services and medication in this Regulation is on the one hand broad and encompassing (e.g., health promotion) and on the other hand very specific and limiting (e.g., medical services and medication) and doesn't place these issues in the broader context of "health". A definition of 'health' would be more consistent with the principles and values underlying the legislation. Further, there is reference in **7.(1)1** which requires agencies to have information on "healthy lifestyles". While the intent is laudable, the term healthy lifestyles is value laden and likely subject to variable interpretation with unintended yet negative impact on individual choices such as sexual practices; dietary choices; relationships and so on. Information on improving health in its broadest context can best be achieved through providing information within a health promotion context as noted in the regulation.

Additionally it is well documented in research that up to half of individuals living in the community receives psychotropic medications, often for no known psychiatric illness, but rather to 'manage' behaviour. The Province has also emphasized the mental health needs of individuals with developmental disabilities through the re-issue of Dual Diagnosis Policy Guidelines and the funding of Specialized Networks. In this context a definition of health in this section should encompass mental health when referring to "health" or "medical" services.

#### ***Recommendations:***

15. A definition of 'health' is added to the regulations as follows: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (WHO, [www.who.int/suggestion/faq/en/](http://www.who.int/suggestion/faq/en/), accessed Feb, 2009)
16. Remove reference to "healthy lifestyles" in the document.

## **Part II General**

### **Health promotion, medical services and medication**

#### **7. (3) Policies and procedures, including documentation, regarding,**

- i. all medical services that are provided to the person with a developmental disability, where a staff member from the service agency is providing assistance to the person with a developmental disability during the service
- ii. self-administration of medication by a person with developmental disabilities

The wording of this Regulation appears to be limited to a requirement to document that occurrence only when staff are involved in a medical appointment. Often a family member or significant other, or the individual themselves will obtain medical services without the staff present. The attendance by individuals independently or with significant others is an empowering experience. However the absence of documentation or reference to communication between staff, person with a developmental disability and family member or significant other regarding such an event will result in gaps in understanding of the treatment being provided.

#### ***Recommendation:***

17. Staff document visits for medical services when they occur by the individual independently or with a significant other, and include any results reported to them by the client and/or significant other.

## **Part II General**

### **Health promotion, medical services and medication**

#### **7. (1) 3 Policies and procedures, including documentation, regarding,**

- i. all medical services that are provided to the person with a developmental disability, where a staff member from the service agency is providing assistance to the person with a developmental disability during the service,
- ii. self-administration of medication by a person with developmental disability,
- iii. any refusals by the person with a developmental disability to obtain or accept medical services that are recommended by a legally qualified medical practitioner or other health professional, and
- iv. emergency medical services.

This Regulation refers to the self-administration of medication by a person with a developmental disability. It is important to note that agency staff often are **administering** medication to individuals in their care and not simply *assisting* in their self administration of medications (as is implied in this Regulation). While administering medications by some routes (injection and inhalation) are controlled

acts, other routes of administration such as oral administration are not (Regulated Health Professions Act, 1991). This component of the regulation could be strengthened by adding an additional comment pertaining to standards for medication administration; training requirements of agency staff in the safe administration of medication and; ensuring the prescribing, monitoring and regular review of medications is carried out by a qualified health care practitioner.

***Recommendations:***

18. The wording of **7.(1) 3** be revised as follows: “Standards, policies and procedures for the...where a staff member is administering or providing assistance to...”

19.The wording of **7.(1) 3-ii** be revised as follows: “safe and effective administration (including self administration), of medication...”.

20. Add an additional bullet under **7.(1) 3-v** as follows: “Regular review and monitoring of all medications by a qualified health care practitioner.”

22. Add an additional bullet under **7.(1)3-vi** as follows: “Consent to treatment.”

23. Add an additional bullet under **7.(1)3-vii** as follows: “Annual training by a qualified health care practitioner on medication administration to all staff administering or assisting in the administration of medications.

**Part II General**

**Policies and procedures on abuse prevention and reporting and their evaluation**

**8. (4)** A service agency shall immediately report to the police any alleged, suspected or witnessed incident of abuse of a person with a developmental disability who is receiving services and supports from the service agency, where the service agency suspects the alleged, suspected or witnessed incident may constitute a criminal offence.

**Notification of incidents of abuse**

**9 .** A service agency shall notify the person’s family or a person acting on behalf of the person with a developmental disability or both, within 24 hours after the service agency becomes aware of an alleged, suspected or witnessed incident of abuse of a person with a developmental disability.

Regulation 8 is a welcome clarification for agency procedures by addressing the issue of potential ‘tainting’ of an investigation by service agencies undertaking their own review prior to contacting the authorities.

Given the extraordinary high rate of victimization and abuse within the population, Regulation 9 requires careful consideration regarding the impact of notification of the family or significant others in the case of individuals who are competent to consent. There is evidence in the literature of distressing consequences to individuals with histories of abuse whose family or significant other have been informed without the competent individual's consent. This can further complicate pre-existing emotional and traumatic symptoms for the person.

***Recommendations:***

24. The family or SDM of clients incapable of consenting for themselves shall be notified within 24 hours after the service agency becomes aware of an alleged, suspected or witnessed incident of abuse of a person with a developmental disability
25. The service provider shall follow the expressed preference of the individual with a developmental disability who is capable of consent with regard to the notification of family or significant others after the service agency becomes aware of an alleged, suspected or witnessed incident of abuse of a person with a developmental disability
26. The service provider shall advise the family or SDM when corrective action has been taken, within the context of the consent as per 24 and 25.

**Part II General**

**Policies and procedures on abuse prevention and reporting and their evaluation**

**Confidentiality and privacy**

- 10.** (1) In addressing quality assurance measures respecting confidentiality and privacy, each service agency shall have the following:
1. Policies and procedures that comply with applicable privacy legislation and its privacy and confidentiality obligations under any funding agreement made under the Act.
  2. Policies and procedures regarding consent to any collection, use or disclosure of personal information

***Recommendation:***

27. As per Recommendations 2, above.

**Part II General**

**Service Records**

- 14 (2)** The service record shall include a copy of the person's,
- (a) Application for Developmental Services and Supports;
  - (b) Supports Intensity Scale needs assessment; and
  - (c) individual support plan

For Application Entities and Developmental Service providers in general, to have a comprehensive understanding of the individual’s history, provide continuity of care and to make appropriate referrals to other providers, particularly in the health field, service records must be broader than this. If a regulation is required regarding content of service records, then the list should reflect the multi-disciplinary nature of a comprehensive support plan.

***Recommendation:***

28. The service shall also include copies of materials that support continuity of care and provide a comprehensive understanding of a persons needs including:

- crisis support plans,
- discharge summaries from hospitalizations,
- multi-disciplinary assessments previously provided, such as psychological, OT, speech & language, psychiatric, behavioural, neurological, genetic assessments

**Part III**

**15 Application and definitions**

“behaviour support plan” means a document that outlines non-intrusive behaviour intervention or intrusive behaviour intervention strategies or both where the strategies are designed to reduce, change or eliminate, or any combination of reduce, change or eliminate, challenging behaviour of the person with a developmental disability, in order to support their inclusion in the community; (“plan de soutien au comportement”)

***Recommendation:***

29. As per recommendation 8.

**Part III**

**15 Application and definitions**

(3) For purposes of the definition of “intrusive behaviour intervention”, the following are examples of intrusive procedures or actions:

3. Secure isolation or time out during a situation where the person with a developmental disability is exhibiting challenging behaviour, where the isolation or time out is in a designated, secure space that is used to separate or isolate the person from others.

This Regulation is further example of the issues outlined in Section 2 under General Comments above. ‘Time out’ is a specific technique that is utilized by professionals who are trained to do such interventions. As well, time out may be an intrusive procedure or may be a non-intrusive procedure, being individually defined depending on the purpose and the design of the individual plan. The prescriptive detail of this Regulation is not appropriate and NADD Ontario recommends that the Quality Assurance Measures more appropriately describe general parameters of quality as they pertain to person centred support plans.

***Recommendation:***

30. Remove and replace as per Recommendations 4, 5, 6 and 7

**Part III**

**15 Application and definitions**

(3) For purposes of the definition of “intrusive behaviour intervention”, the following are examples of intrusive procedures or actions:

4. Prescribed medication to control behaviour.

We assume the intent of 15(3)(4) is to address the historical overuse of neuroleptic medication for aggressive or challenging behaviour, however this Regulation, as written, appears to leave the untrained staff person to assume that all prescribed medications are for purposes of controlling behaviour and therefore intrusive. This reinforces an anti-medical model stance. There is a critical role for medication in the life of some people based on a best practice assessment model, as challenging behaviour may be symptomatic of an underlying medical or mental health condition which requires a medication or PRN as an appropriate component of a comprehensive treatment plan. There are guidelines and established best practices to ensure the appropriate use of such medication in other jurisdictions (e.g., Alberta, United Kingdom).

This Regulation is again an example of too prescriptive a regulation that could be appropriately described in more general parameters of quality as they pertain to Person Centred Support Plans.

***Recommendations:***

31. Remove ‘prescribed medication to control behaviour’ from the definition of intrusive behaviour intervention, as per Recommendations 4, 5, 6 and 7.

32. The Ministry undertakes to establish an expert panel to develop a Policy Directive regarding standards and guidelines for the administering of medication applicable to the Ontario context.

### **Part III: Behaviour Intervention Strategies**

#### **15 Application and definitions**

“non-intrusive behaviour intervention” means the use of strategies for the purpose of changing the behaviour of another person and includes strategies such as de-escalation, diversion and other techniques that do not require the use of an intrusive behaviour intervention. (“intervention comportementale non perturbatrice”)

Again, defining behaviour interventions as strategies designed to ‘change the behaviour of another person’ places the onus for the behaviour on the individual with a developmental disability, rather than acknowledging the role of external factors, such as concerns in the environment, the interactions or approaches of staff or others, unmet physical or mental health needs. A Policy Directive would also be a more appropriate means of addressing this level of technicality.

#### ***Recommendation:***

33. As per Recommendations 4, 5, 6, 7 and 8

### **Part III: Behaviour Intervention Strategies**

#### **General behaviour intervention strategies, training**

- 17.** (1) Each service agency shall ensure that all of its staff members who work directly with persons with developmental disabilities who exhibit challenging behaviour are trained in the use of behaviour interventions.
- (2) Each service agency shall ensure that staff members who work directly with persons with developmental disabilities who exhibit challenging behaviour do not use behaviour interventions until after they have been trained on the use of behaviour interventions. 13
- (3) Each service agency shall maintain training records on the use of behaviour interventions for staff members who work directly with persons with developmental disabilities who exhibit challenging behaviour.
- (5) Each service agency shall ensure that volunteers do not use behaviour interventions.

In Bill 77, community participation support services are defined as ‘services that assist an individual in social and recreational activities, work activities, and volunteer activities’. The underlying intent appears to be social inclusion. The earlier Regulation regarding non-intrusive behaviour intervention is rather broad and includes interventions that would occur every day all day long in a person’s life. Most plans of this nature incorporate a habilitative component, a medication component as well as positive behavioural interventions and crisis components, which may include Crisis Prevention Intervention. Together with Section 17 and subsequent requirements for documentation, the implementation of the Regulations will be difficult and too restrictive in the context of supporting community inclusion.

Families and volunteers utilize non-intrusive and positive behavioral interventions as guided by the staff team for the purposes of supporting consistent implementation of an individual's Person Centred Support Plan with the goal of achieving community inclusion. If they were not to do so the overall plan would be disrupted and inconsistently implemented. The Regulations are inconsistent with what occurs in day to day practice and do not acknowledge all members within a circle of support or where an individual might participate in the community. To meet the requirements of the Regulation people with challenging behaviour will only be able to participate in the community with additional paid staff...

As noted earlier the prescriptive detail of this Regulation will be confusing to implement and is not appropriate. NADD Ontario recommends that the Quality Assurance Measures more appropriately describe general parameters of quality as they pertain to person centred plans.

***Recommendation:***

34. As per Recommendations 4, 5, 6, 7 and 8

**17. General behaviour intervention strategies, training**

17 (4) The training on the use of behaviour interventions for staff members including refresher courses required under a training program, may be provided by service agency or by a third party.

It is not clear in this Regulation what type of training is being referred to e.g., is this CPI or training related to specific implementation of a person centred support plan? This again is too detailed and prescriptive and NADD Ontario recommends that the Quality Assurance Measures more appropriately describe general parameters of quality as they pertain to person centred support plans.

***Recommendation:***

35. As per Recommendations 4, 5, 6, 7 and 8

**18. Behaviour Support Plan**

(4) The service agency shall ensure that the behaviour support plan,

- (e) is signed by the person with a developmental disability or a person acting on their behalf;
- (f) is approved by a psychologist or a psychological associate

18(4) (e) requires clarification regarding the purpose of sign off. A best practice approach involves at a minimum the participation of the individual, the family or significant other in the development of such a plan, including the use of intrusives in terms of familiarizing the individual with their options, obtaining input as to past experiences and the preferred approach. This is part of good individualized practice and likely the intent of this Regulation.

If however the purpose is for consent then the issues of consent highlighted earlier apply.

18 (4) (f) again raises the issue of a too detailed Regulation infringing on the purview of other regulatory bodies where existing professional practice guidelines apply and can inform practice in the field. For example, it is not within the scope of practice of psychology to sign off on prescribed medication.

Additionally we reiterate from an earlier submission by NADD Ontario that there are not enough psychologists or associates who are registered in the relevant area of practice and who have specific experience in the area of developmental disabilities. Also of note is that it is unlikely that a psychologist or associate would be willing to sign off on such plans without their involvement in the development of the plan. The intent however is laudable and should be a goal within the sector. Plans as to how this will be addressed in the interim at the point of proclamation of the Act and its regulations as well as how this human resource gap will be addressed over the longer term (e.g., 10 years) are required.

***Recommendations:***

36. Staff document in the service record the process for involvement and input by the person with a developmental disability and their family/significant other in the development of person centred plans. This would also include signature of the person with a developmental disability and /or family/significant others for those unable to provide informed consent.
37. As per Recommendation 31.
38. The Ministry, in consultation with experts in the field, establish formal plans to address the interim gap regarding psychology sign off in order to achieve the requirements of Regulation 18 (4) (f)
39. The Ministry, in consultation with experts in the field, establish a human resource 10 year plan to address the gap in psychology and psychology associates required to achieve the requirements of Regulation 18 (4) (f).
40. Notwithstanding the above, we reiterate Recommendations 4, 5, 6, 7 and 8

**Use of intrusive behaviour intervention**

20 (4) A service agency shall ensure that when intrusive behaviour intervention is used, the person with a developmental disability is monitored on a regular basis.

The wording of this Regulation is vague regarding the service agency's obligation to monitor the use of intrusive measures, and would benefit from a definition for 'monitoring on a regular basis'. Additionally, in the event of intrusive interventions, the family or SDM should be informed within a prescribed period of time when an intrusive intervention was used and the circumstances, and within the context of the appropriate consents.

Once again and as noted earlier the prescriptive detail of this Regulation is not appropriate and NADD Ontario recommends that the Quality Assurance Measures more appropriately describe general parameters of quality as they pertain to person centred support plans.

***Recommendations:***

41. Regular monitoring be defined as every 15 minutes at a minimum with appropriate documentation in the service record.
42. The family or SDM should be informed, within 24 hours of when an intrusive intervention has been implemented, and within the context of the appropriate consents.
43. Notwithstanding the above we reiterate Recommendations 4, 5, 6, 7 and 8

**Part IV QUALITY ASSURANCE MEASURES WITH RESPECT TO SERVICE AGENCIES, RESIDENTIAL SERVICES AND SUPPORTS**

**Supporting the well-being of the person, general**

**23.** In addressing quality assurance measures respecting the well-being of the person, each service agency shall ensure the following is done:

1. Assistance is provided to the person to attend regular medical and dental appointments, as appropriate, and that a log is kept or documentation is kept on file with respect to the person's regular medical or dental appointments.
3. Information as applicable and appropriate is provided to the person with respect to,
  - i. prescription medication
  - ii diet and nutrition
  - iii personal hygiene,
  - iv personal fitness,
  - iv sexual health, and
  - vi behaviour that may pose a threat to the person's health, safety or well-being.

As per Recommendation 15 regarding the definition of health – Regulation 23 (3) implies the broader perspective of health, however the language in 23 (1) refers only to medical and dental appointments.

***Recommendations:***

44. As per Recommendation 15.
45. Regulation 23 (1) be reworded as follows:  
Assistance is provided to the person *to attend regular health appointments as recommended in the Ontario Primary Care Guidelines ( Sullivan, In press 2009)* and that a log is kept or documentation is kept on file with respect to the person's regular *health care* appointments.

**Part V QUALITY ASSURANCE MEASURES WITH RESPECT TO APPLICATION ENTITIES**

**Records**

- 34. (2)** The record shall include a copy of the person's,
- (a) Application for Developmental Services and Supports;
  - (b) Supports Intensity Scale needs assessment; and
  - (c) individual support plan.

***Recommendation:***

46. As per Recommendation 28.