Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019

Submission to the Parliamentary Joint Committee on Human Rights

August 2019

About the Office of the Public Guardian Queensland

The Office of the Public Guardian (OPG) is an independent statutory office which promotes and protects the rights and interests of children and young people in out-of-home care or staying at a visitable site, and adults with impaired decision-making capacity. The purpose of the OPG is to advocate for the human rights of our clients.

The OPG promotes and protects the rights and interests of adults with impaired decision-making capacity through its guardianship, investigations and adult community visitor programs:

- The guardianship program undertakes both supported and substituted decision-making in relation to legal, personal and health care matters, supporting adults to participate in decisions about their life and acknowledging their right to live as a valued member of society.
- The investigations program investigates complaints and allegations that an adult with impaired decision-making capacity is being neglected, exploited or abused or has inappropriate or inadequate decision-making arrangements in place.
- The adult community visitor program independently monitors visitable sites (authorised mental health services, community care units, government forensic facilities, disability services and locations where people are receiving NDIS supports, and level 3 accredited residential services), to inquire into the appropriateness of the site and facilitate the identification, escalation and resolution of complaints by or on behalf of adults with impaired decision-making capacity staying at those sites.

When providing services and performing functions in relation to people with impaired decision-making capacity, the OPG will support the person to participate and make decisions where possible, and consult with the person and take into account their views and wishes to the greatest practicable extent.

The *Public Guardian Act 2014* and *Guardianship and Administration Act 2000* provide for the OPG's legislative functions, obligations and powers. The *Powers of Attorney Act 1998* regulates the authority for adults to appoint substitute decision makers under an advance health directive or an enduring power of attorney.

Submission on the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019*

Position of the Public Guardian Queensland

The Office of the Public Guardian (OPG) appreciates the opportunity to provide a submission to the Parliamentary Joint Committee on Human Rights (the Committee) in relation to the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (the Principles) as part of the Committee's functions of examining legislative instruments for their compatibility with human rights (under section 7(a) of the *Human Rights (Parliamentary Scrutiny) Act 2011).*

The Principles introduced by Ministerial instrument, appear to be an effort by the Commonwealth Government to regulate restrictive practices (physical and chemical restraint) in aged care. The OPG first became aware of the existence of the Principles when several aged care service providers contacted the OPG on 2 July, seeking consent from guardians to the use of physical restraint on guardianship clients in aged care. The Principles now form part of the *Quality of Care Principles* under the *Aged Care Act 1997.* While the Commonwealth should be applauded for recognising this critical need to regulate such practices in this sector, these Principles raise significant human rights implications and fall significantly short of industry practice and minimum standards in comparable sectors, in particular the national standards in the National Disability Insurance Scheme (NDIS) and disability sector regarding regulation of restrictive practices. In fact – the new law creates many more problems than it solves.

Of paramount concern to the OPG is that the new Principles appear to drastically regress protections of the human rights of every adult (whether an older person or a young person with disability) living in an aged care facility; and directly impacts the role and functions of state and territory-based guardians and appointed decision-makers. The OPG is deeply concerned that the drafting and introduction of the Principles are but a rushed attempt to regulate restrictive practices in aged care, without due consideration of the human rights of the people it affects. The Principles will result in disproportionate restrictions being placed upon a resident's fundamental human rights, with the use of restrictive practices having no proportional or direct link to an evidence-based response to address behaviours of concern.

The passing of such law without consultation, and based on a ministerial instrument rather than an Act of Parliament only reinforces how critical it is that a United Nations Convention on the Rights of Older Persons is developed, and Australia becomes a signatory.

Recommendations

Recommendation 1:
It is recommended that the Committee reports back to both Houses of Parliament indicating that:

a) this law disproportionately limits the human rights of all aged care facility residents, and
b) the limitations of human rights regarding the use of physical and chemical restraint are so broad as to not be rationally connected with addressing any behaviours of harm or concern, and
c) the law should be nullified.

Recommendation 2:

It is further recommended that the Committee report back to both Houses of Parliament that the Commonwealth Government should:

a) undertake a public consultation, and work collaboratively with states and territories to develop a human rights compliant statutory regime to govern the use of restrictive practices in aged care facilities in order to provide proportionate responses to behaviours of harm or concern that are sought to be addressed, and
b) ensure that the use of restrictive practices are appropriately regulated in aged care facilities on an equal basis as afforded to other persons with disability, such as through the NDIS Quality and Safeguards Framework.

Submission

1. Regulation of restrictive practices under the Principles

Any use of restraint significantly interferes with a person's fundamental human and legal rights. Restricting the liberty of a person is such a significant infringement of a person's human rights it requires strict guidelines and regulation to justify being overridden, with justifications required in each individual instance. Article 14 of the *Convention of the Rights of Persons with Disabilities* requires that the existence of a disability should in no case justify a deprivation of liberty, nor legitimise 'arbitrary' detention. However, given the extraordinary breadth of the definition within the Principles, of what can be considered 'physical restraint' (as discussed further below), physical restraint *will* apply arbitrarily to all residents in aged care, with absolutely *no connection* to any perceived behaviours of concern. Further, the new Principles give no consideration to a person's right to decision-making support, or choice and control. The right of equal recognition before the law under article 16 of the *International Covenant on Civil and Political Rights* and article 12 of the *Convention on the Rights of Persons with Disabilities* enshrining the right to autonomy, dignity, choice and control are completely by-passed and ignored.

The new Principles seek to introduce regulations governing the use of physical restraint and chemical restraint where a resident in an aged care facility is unable to provide informed consent to their use. However, there is no requirement under the new Principles to consider or address how the service provider will reduce or eliminate the use of restrictive practices, nor any requirement to develop positive behaviour support plans which are now industry standards within the national disability sector. There are significant concerns regarding the authorization, use, and lack of any independent oversight of such practices. The Principles appear in effect, to merely provide a further requirement for service providers to 'tick off' without any clear obligation to seek the person's consent, keep the person informed, or consider the person's rights, will or preferences.

The Victorian Law Reform Commission has stated that "liberty is one of the most important values protected by the common law. [Therefore] any interference with a person's liberty is unlawful unless authorised by law".[1] However, it should be noted that "a restriction upon freedom is not rendered lawful simply because its motivation is benign".[2]

Whether intended or otherwise, the law significantly interferes with State guardianship legislation and compromises not only the powers of the Public Guardian of Queensland, but that of private guardians and people appointed under Enduring Powers of Attorney. A guardian does not have complete authority over another person's life. Instead the

[1] Victorian Law Reform Commission, *Guardianship Final Report 24,* 2012, p. 320

[2] Williams, M., Chesterman, J., and Laufer, R., 2014, "Consent versus scrutiny: Restricting liberties in a post-Bournewood Victoria", *Journal of Law and Medicine*, Vol 21, p. 657

guardianship board/tribunal decides in which particular domains a person requires a guardian and then makes an order regarding those specific domains. Every guardianship order specifically identifies the particular domains in which a guardian has been appointed. Disappointingly, these Principles purport to give powers to a guardian to decide whether restraint should be used *regardless* of what domain they have been appointed as a guardian for in a person's life. In my view, this asks guardians to act outside of State Guardianship law and places my agency and the community in a highly compromising position.

Given the significant impact that such laws have upon formally appointed guardians under state-law, it is astounding that such a law was passed without any consultation with the states or territories, nor with state-based guardianship and administration bodies.

The OPG's key concerns are set out below.

New Principles governing physical restraint

The OPG's position aligns with the submission that the Committee has received from the Office of the Public (OPA), Victoria, and the OPG supports and (at certain points) reiterates the issues that OPA has raised. Under the new Principles (s 15F(1)) a service provider cannot use physical restraint unless they have the consent of the resident, or their representative.

The definition of physical restraint is extremely broad and all-encompassing as to include 'any restraint' other than chemical restraint. This could arguably include anything from placing an adult in a secure facility with a key pad to enter/exit, or in a locked ward or room, to applying a lap belt, or attaching bed rails or locked chair tray tables if the mechanism restricts their free movement. This should be seen in contrast to the extensive detail provided under the NDIS Quality and Safeguards Rules regarding the use of restrictive practices under which physical restraint is differentiated from seclusion, chemical restraint, mechanical restraint, and environmental restraints (such as restricting a person's access to places or objects), and the significant oversight and regulation in their use <u>both</u> at the Commonwealth and state level. The NDIS provides a significantly more robust approach to the use of restraint and far stronger safeguards. For example, in Queensland under the NDIS at full scheme we continue to have rigorous oversight of the use of restrictive practices, not only through the authorisation process that is maintained regarding the use of restrictive practices, including ensuring that a positive behaviour support plan is in place, but also through the ability to monitor the use of restrictive practices in certain settings through the oversight of the community visitor program in NDIS disability funded sites.

There is significant lack of regulation regarding the 'representative' who can 'consent' to the use of restrictive practices on the person's behalf. A representative under section 5 of the new Principles can be either a person nominated by the consumer, or a person '*who nominates themselves*' and who the aged care facility is satisfied 'has a connection with the consumer and is concerned for the safety health and well-being of the consumer'. This could include persons who are partners, close relations, or other relatives, an enduring power of

attorney, an appointed guardian, or a person who 'represents the consumer in dealings with the organisation'. This gives rise to the following significant concerns:

- There is no clear hierarchy of persons should there be a dispute as to who fulfils the role. OPG, as guardian of last resort, is often appointed due to other connections/relatives in the person's life acting inappropriately; making self-serving decisions and/or engaging in elder abuse. It is highly concerning to OPG that people found unsuitable by a state/territory tribunal to make decisions in a person's life, could be enabled under the Principles, to make unrestricted decisions about a person's liberty and restraint.
- No fiduciary or other responsibilities are attached to the role of 'representative'.
- *Any* person can nominate themselves as a representative; however, there is no mechanism for the resident to veto the person who is nominating themselves, which is a significant concern particularly where there are familial disputes, or a relationship of abuse and duress that may not be discerned or known by the service provider.
- There are no definitions of 'relative' within the *Aged Care Act 1997,* and even though the terms 'partner' and 'close relation' are defined in the *Aged Care Act*, they do not arise in an equivalent context to the authorization of the use of physical restraint.
- It is deeply concerning that a person who 'represents the consumer in dealings with the organisation' would have the power to provide consent to the use of physical restraint. This is so broad it could include an advocate, or other persons with no formal authority or clear relationship with the person to make such decisions, regardless of the benevolence of their intent.

While the Principles require that the use of a physical restraint should be regularly monitored to determine whether the adult is demonstrating signs of distress or harm, and the necessity for the restraint, there are no guidelines to govern this over oversight to enforce this. There is no consideration at all of the person's rights, will and preferences either before, after or during this event in accordance with article 12 of the *Convention on the Rights of Persons with Disabilities*. Likewise, there is no time limit or duration specified, which would protect the vulnerable person by limiting the period of time for the use of the restraint, or the period governing an authorisation. It is not clear whether physical restraint can be authorized 'generally' or consent is to be obtained on each and every occasion, and whether it is only for a specific time, or for as long as is required.

The most pressing and disturbing concern is the unintended consequence of what happens when no consent is given. There could be significant pressure placed upon a 'representative' to consent, as the lesser of two evils. For example, pressure could be placed upon the person to consent to an adult being placed in a locked or dementia ward, or restrained in a chair with a lap belt, otherwise they may be refused accommodation at the facility. More significantly, pressure could be placed on the 'representative' to consent, or the facility (due

to lack of staffing and other pressures) could resort to chemical restraint instead, circumventing the need for consent of the representative and 'silencing' the problem. The reality of such an event occurring is reinforced by the evidence received to date by the Royal Commission into Aged Care Quality and Safety (Royal Commission).

Importantly, even if none of the above concerns were live (which sadly, they are), how will the new Principles or any aspects of the Commonwealth legislative amendment have any real impact if they are not being monitored by an empowered, legislated Community Visitor Scheme? One might observe from the above, that the new Principles give way to even greater potential for abuse in an environment where there is really no one 'watching'.

New Principles governing chemical restraint

Under the new Principles, an aged care provider may use chemical restraint where:

- A medical practitioner or nurse practitioner has assessed the resident as requiring the restraint and has prescribed the medication
- The practitioner's decision to use the restraint has been recorded in the resident's care and services plan, and
- The resident's representative is informed before the restraint is used, if it is practicable to do so.

It is deeply concerning that the system has regressed recognition of a person's human rights so deeply by enabling non-independent medical, or nurse practitioners to determine the use of chemical restraint. Visiting medical practitioners, and nurse practitioners (particularly those employed by the aged care facility) have a significant conflict of interest, and a divided loyalty between the facility (and its staff) and the person. The only independent 'safeguard' under the new Principles is the notification of the representative (where possible) before the event, or as soon as possible after the restraint starts to be used. There is no mechanism for objection, or challenge, and limited (if no) recourse to address concerns regarding the authorisation and use of such practices. Given the ongoing representations being made to the Royal Commission with respect to the use of chemical restraint and sedation of persons in aged care facilities, this represents a significant worsening in rights protection for these adults. If the new Principles remain in place unamended, the OPG predicts there will be a rise in the use of chemical restraint upon aged care residents. This is foreseeable because a weaker threshold has been applied in relation to consent – and it is likely that in a resource-constrained environment, with staff who are 'stretched', they will opt for the restraint which would appear to be 'less work' for them. This is extraordinarily dangerous.

In addition to this, given the significant number of residents in aged care facilities that have no visitors (approximately 40% as reported by the Australian newspaper on 25 October 2017), there are concerns that there will be no appropriate representatives to either consent to the use of physical restraint, or be informed of the use of chemical restraint. This risks

burdening the states and territories with increased appointments for guardians to meet the newly created 'gap' in appropriate representatives, which leads me to the final concern regarding the impact upon, and intersect with, state guardianship.

Impact upon guardianship and the OPG

The new Principles (that have been introduced without consultation with the states and territories) expand the decision-making powers of appointed guardians by conferring a completely *new* function upon guardians to consent to the use of physical restraint. However, there is *no legal authorisation* for a guardian *to make decisions* regarding the use of physical restraint in an aged care facility under Queensland guardianship legislation. This is *outside the normal scope of a guardian's decision-making duties* and obligations under relevant state law. For example, an appointment to make decisions for an adult with respect to accommodation , may not necessarily include the power to make decisions regarding physical restraint. For example, making decisions regarding the use of bed or chair restraints) but may include the power to make decisions regarding a person being accommodated in a locked facility or ward. This legislation will result in absurd circumstances where to 'tick a box' the service provider will be required to seek the consent of a guardian, while for a guardian, such decision-making will be outside the scope of their decision-making appointment under Queensland law. The OPG is already having aged care service providers contact guardians to seek consent to the use of physical restraint, and seeking guardianship appointments through the Queensland Civil and Administrative Tribunal in order to seek consent of the use of physical restraint.

This places state and territory guardians in a catch 22 situation. To consent to physical restraint would be a significant breach of a person's human rights and contrary to the rights, and decision-making appointment recognised under guardianship law. Yet where no consent is obtained, an adult may be denied access to accommodation at the facility at all (which OPG is already seeing), or worse still, the service provider upon not obtaining consent to physical restraint may resort instead to the more restrictive means of chemical restraint, leaving the person with no independent oversight, or legal recourse regarding their rights.

The legislative introduction of the new Principles has occurred without consultation with the states/territories, and relevant statutory Public Guardians and Advocates. However, the Commonwealth's expansion of decision-making regarding restraints to include state-based guardians will have a substantial impact upon the resourcing and funding of these bodies. Regardless of whether a guardian can or cannot provide consent under state law, an aged care service provider remains obligated under the Principles to seek consent from the person's representative to satisfy compliance with their obligations under the new Principles. Therefore, if the Public Guardian is appointed as the person's guardian, the aged care facility will likely still contact OPG in order to *seek consent* to the use of physical restraint where *the service provider* determines the OPG guardian to be the person's representative in order to meet their own legislative obligations.

Finally, the introduction of the new Principles also raises the potential for abuse, or exploitation, with potential implications for the OPG's investigations function. The new Principles confer significant decision-making powers upon a person's formal or informal decision-maker in relation to the use of physical restraint. There is no corresponding regulation or independent oversight of the use of physical or chemical restraint under the new Principles, and limited recourse for a representative to express concerns about the use of chemical restraint. Further, there is also potential for aged care providers to be motivated to use chemical restraint to make it easier for staff, and less costly to care for residents, particularly with respect to those residents who exhibit challenging behaviours. Even more concerning is that residents who *are* restrained are also at risk from harm, including death. Therefore, this may lead to an increase in allegations of inappropriate or inadequate decision-making regarding authorisation of the use of physical restraint, or allegations of abuse of vulnerable adults with impaired capacity who are living in aged care facilities in Queensland.

The solutions proposed under the new Principles fall woefully short of the high standards regarding the use of restrictive practices in other sectors. Not only that, but they have been created in a vacuum. Without the following three tiers there is no strength or safeguarding of this regulation – and it may be as good as redundant in its intentions:

1. Community Visitors with legislated powers to monitor, inquire, complain and advocate;
2. An investigative body empowered with disciplinary measures;
3. Proper Regulation of restraint.

Any solutions should not be solved by rushed legislative proposals. There should be considered and wide public consultation that engages meaningfully with older adults in the aged care sector, persons with disability living in aged care facilities, as well as state and territory governments and key statutory bodies such as Public Advocates, Public Guardians and Administrators. A broad suite of solutions needs to be developed to address the use of restrictive practices including:

- A Commonwealth regime that mirrors the requirements that the Queensland legislation places in relation to the 'authorisation' of restrictive practices
- The three tiers of enforcement (above)
- providing solutions to address the adverse consequences of physical restraints experienced by aged persons in nursing homes
- establishing and enshrining in law industry wide standards and guidelines regulating the use of restrictive practices, drawing on the standards established in the disability sector under the NDIS
- implementing dementia friendly environments

- increasing awareness of the risk of restraints while driving best practice to ensure the reduction and where possible elimination in their use, and
- introducing reporting, monitoring and authorisation processes regarding the use of such practices that is overseen by a qualified and independent body.

2. Need for high regulatory standards for restrictive practices

The unlawful application, or inappropriate use of restrictive practices are significant infringements of a person's human rights. Given that historically, the unregulated use of restrictive practices has been one of the greatest problems for residents in aged care facilities, there are some recommendations included below for improving regulation in the aged care sector.

In Queensland, the *Guardianship and Administration Act 2000* (Qld) (GAA) and the *Disability Services Act 2006* (Qld) collectively regulate the use of restrictive practices for adults with impaired decision- making capacity in Queensland disability service settings. Prior to the introduction of this statutory regime, the use of restrictive practices in the Queensland disability sector was self-regulated, and was subject to misuse. The current aged care sector bears a striking similarity to the disability sector prior to its regulation. After extensive review,[3] it was acknowledged that self-regulation had not worked, and that legislative oversight was the only way to achieve proper regulation of the use of restrictive practices. This led to implementation of the strong regulatory scheme which now oversees the use of restrictive practices in Queensland.

The OPG strongly believes that consideration should be given by the Commonwealth to adopting a model equivalent to the Queensland statutory regime. This regime has proven strength in safeguarding an adult's rights and interests through comprehensive regulation of the assessment, approval, monitoring and review of the use of restrictive practices by disability service providers that includes the establishment of a positive behaviour support plan[4]which is designed to reduce and eliminate the use of restrictive practices. Queensland is considered world-leading in its regulation of restrictive practices in the disability sphere.

Need for legislative regulation of restrictive practices in aged care facilities

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[3] See the Hon. William Carter, Q.C. report, *Challenging Behaviour and Disability: A Targeted Response* (2006).

[4] Positive behaviour support is a practice that means that restrictive practices can be removed if strategies are implemented to avoid or de-escalate behaviours.

It is recommended that a national legislative framework be established under the *Aged Care Act 1997* (Cth) to regulate, and prohibit the use of restrictive practices in aged care, except as a last resort.

The primary purpose leading to the use of restrictive practices should be to protect the person, or others, from harm, and should only be used as an *absolute last resort* and be the least restrictive option available, with requirements to demonstrate and articulate which other options have been tried and used. Any use of restrictive practices should be accompanied by a plan for reduction and elimination of its use altogether, with regular revision of their use, and authorisation for the shortest time possible. Provision of a legislative scheme should provide: stronger safeguards consistent with that proposed under the NDIS; transparency in the use and prevalence of restrictive practices; a mechanism for independent oversight for people in aged care facilities including the use of restrictive practices; and ensure clarity regarding the legal and appropriate use of restrictive practices in the aged care system. The regime should include strict penalties for abuse and misuse of restrictive practices, and obligate aged care facilities to develop and use positive behaviour support plans in line with the aim of reducing and eliminating the use of restrictive practices in services for the relevant person.

Need for regulation of restrictive practices to specifically address age-related issues

In developing a legislative regime, consideration should be given to whether there should be either a nationally consistent legislative scheme or a single piece of Commonwealth legislation that governs the use of restrictive practices for both children and adults across the various service sectors, including aged care, disability and health. A national approach could ensure consistent, independent regulation of the use of all restrictive practices upon persons of all ages, regardless of whether the practices are used in aged care, health, residential or disability facilities, or in the home.

However, the legislative regime governing aged care facilities should be designed to take into account not only disability-related behaviours of harm, but also issues specific to older persons. Evidence suggests that there is an increasing number of people with dementia who are being subjected to the use of restrictive practices in aged care settings. Often adults with dementia may find themselves at risk of harm as a result of ad hoc, poorly applied, or misused restrictive practices. Dementia wards generally house a broad range of people with varying degrees of dementia, some of whom may be relatively high functioning. While the OPG has observed that there is a tendency towards classifying dementia wards as 'high care' and the motivation behind this classification is not known directly by the OPG, the result is that such a classification can result in receipt of greater funding from the Commonwealth.

Dementia is different from other cognitive conditions which can be treated with therapeutic interventions. Unlike other cognitive conditions, dementia is a terminal illness that cannot always be addressed by traditional modalities of positive behaviour support, or through the

use of anti- psychotic medications as a form of treatment or chemical restraint. A significant risk in using restrictive practices on adults with dementia is that they can: negatively impact the adult; lead to an escalation in harmful behaviours; or cause harm to the person. As a degenerative illness, dementia should be treated within a palliative care model on the understanding that as the illness progresses the person is unlikely to improve. Currently, there is no equivalent to a specialised positive behaviour support concept to reduce and eliminate the use of any restrictive practices within aged care facilities that is designed for persons with dementia, and their use in these settings can amount to a breach of the person's human rights. An appropriate model of care designed for dementia patients should be developed for managing challenging behaviour, and should be based upon providing the adult with dignity and respect, encouraging and supporting them to live life as much as their health permits at any given time.

Development of a national protocol on reducing and eliminating restrictive practices in aged care

Australia already has a clear national commitment to reducing and eliminating the use of restrictive practices in the disability and mental health sectors within Australia. It would appear to be a stark omission that no such equivalent protocol exist for the aged care sector. This represents a significant failure to recognise the equal rights of older persons, compared with the rest of society. OPG therefore recommends that a similar national protocol be established for aged care services.

In the OPG's experience, legislative recognition alone is insufficient to effect change; aged care practice and service delivery culture must also be addressed to ensure effective implementation. This requires investment in training and education resources, and the establishment of a national senior practitioner (equivalent to that of the NDIS) to oversee implementation of the statutory framework and protocol.

Community visitor oversight of aged care

It is also recommended that the Commonwealth makes legislative provision for increasing its oversight of the practices and quality of care within aged care services, through establishing a fully funded federal community visitor program with legislated imprimatur. It is strongly recommended that the Commonwealth scheme is properly resourced; and provided with more 'teeth' in line with the Queensland adult community visitor function (as administered by the OPG), so that issues relating to abuse, neglect and exploitation of persons in aged care are identified and addressed.

A significant number of OPG clients under guardianship (including young people with intellectual disabilities) reside in aged care facilities. OPG guardianship officers have observed that the use of unregulated restrictive practices has been prevalent in aged care facilities. However, without adequate oversight such as through independent community

visitors, these adults remain vulnerable to abuse through the unregulated use or misuse of restrictive practices. Further, the current aged care visiting program overseen by the Commonwealth is voluntary, and in the experience of the OPG has inconsistent quality of oversight and service across facilities. Anecdotal evidence suggests that the community visitors in aged care facilities generally take on a 'friendship' role to the resident. While building a strong relationship of trust with residents is important, without advocacy, monitoring and oversight, issues of abuse and neglect can remain unaddressed. In the OPG's experience, it is only if these functions are legislated, that safeguards can be considered to be in place and a genuine shift can be observed.

The OPG adult Community Visitor Program has statutory responsibility (under the *Public Guardian Act 2014*) to visit adults with impaired capacity who are living or receiving services at government funded facilities such as authorised mental health services, disability facilities, and level 3 accredited residential services. Community visitors can make inquiries and lodge complaints for, or on behalf of, residents of the sites listed above. They also have broad legislative powers to do all things necessary to perform these functions. Community visitors play an important role in identifying abuse which may otherwise remain undetected or unreported in these settings, and are a vital means of supporting adults to navigate complaints mechanisms. As a paid visitor scheme, it also has the advantage of ensuring staff are professionals with access to training and support who are equipped to provide rigorous assessment of rights protection and advocate for resolution of issues. It also means that structured duties in undertaking these functions can be managed within the terms of a contract.

The OPG also supports the Australian Law Reform Commission's recommendation 4-14 under their report *Elder Abuse – A National Legal Response (ALRC Report 131)* regarding the need for the Commonwealth to develop national guidelines for its aged care community visitors' scheme, including policies and procedures for visitors to follow if they have concerns about abuse or neglect of care recipients. Guidelines should include mechanisms to identify and address concerns of abuse or neglect, including referring older persons to appropriate advocacy and support services. Such mechanisms should empower older persons to overcome systemic barriers and support them to participate in their own rights protection.

Concluding remarks

The OPG strongly opposes the regulation of physical and chemical restraints in the manner proposed under the Principles, and is concerned that this law has significantly regressed the

protection of the fundamental human rights of residents in aged care facilities. It strongly recommends that this law be nullified, and that a proper full and public consultation which includes Public Guardians and Public Advocates from each Australian jurisdiction is undertaken to develop appropriate and effective regulation of restrictive practices that is proportional to the behaviour that these restrictive practices are seeking to address. The OPG believes this is the only way to ensure the human rights of vulnerable people in residential aged care facilities are protected and promoted.

The OPG would be pleased to lend any additional support as required.

Should clarification be required regarding any of the issues raised, the OPG would be happy to make representatives available for further discussions.