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13 August 2019

The Secretary
Parliamentary Joint Committee on Human Rights
PO Box 6100
Parliament House
CANBERRA ACT 2600

By email: human.rights@aph.gov.au

Dear Secretary,

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

I am writing in relation to the Quality of Care principles to minimise the use of restraint in aged care, which were made on 2 April 2019 and commenced on 1 July 2019.

I understand that the Committee has responsibility to examine legislation in accordance with the *Human Rights (Parliamentary Scrutiny) Act 2011* for compatibility with human rights. I respectfully request that, when considering the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019, the Committee considers the matters outlined below and recommends the disallowance of this instrument.

I have had the benefit of reading the following correspondence sent to the Committee in relation to this instrument:

- Letter from Human Rights Watch, dated 23 May 2019
- Letter from the Public Advocate, Victoria dated 11 July 2019.
- Submission from the Public Guardian, Queensland dated August 2019.

I support all of the concerns raised in those submissions. I would like to re-emphasise for Committee members some particular concerns raised in those submissions.

Use of a legislative instrument to introduce a restrictive practices regime

As noted in Dr Colleen Pearce, Public Advocate, Victoria's letter, at common law, the use of restraint, whether physical or chemical, constitutes a criminal offence unless it is properly authorised. This position has also been supported by the Australian Law Reform Commission (ALRC) in its June 2016 *Elder Abuse Issues Paper,* in which it recognised that some restrictive practices can constitute elder abuse, deprive people of their basic legal and human rights and be classified as assault, false imprisonment and other civil or criminal acts.[1]

Dr Pearce also makes the relevant point:

> Given the legal and human rights affected by the use of restraint and seclusion, it is surprising, that their regulation in aged care is by a ministerial instrument and not by an Act of Parliament after consideration and debate. (p 1 of letter from Public Advocate, Victoria.)

[1] Australian Law Reform Commission, *Elder Abuse Issues Paper* (IP 47) (June 2016) 238.

In my respectful submission, the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 do not formally authorise the use of physical or chemical restraint. Section 15E of the amendments specifically states:

> This Part does not affect the operation of any law of a State or Territory in relation to restraint.

It then goes on to state that an approved aged care provider must not use physical or chemical restraint in relation to a consumer unless they have done certain other things listed under sections 15F and 15G of the instrument. However, it falls short of expressly formally authorising the use of physical or chemical restraint in aged care.

The primary object of the *Aged Care Act 1997* is to "provide for funding of aged care" (section 2-1(1)(a)). It lists a range of issues that the legislation is concerned with, including promoting high quality of care and accommodation; protecting health and well-being; facilitating access to aged care services; providing respite care; planning for the delivery of aged care; and promoting ageing in place. There is no mention in the objects of the *Aged Care Act* that it is to also provide for the use of restrictive practices in aged care. Considering the use of restraint is a serious infringement of a person's legal and human rights and must be formally authorised by law and justified in each case, it is reasonable to expect that any legislative amendment intended to formally authorise the use of restrictive practices in residential aged care (actions that would otherwise constitute criminal acts against a person), should be made in the primary legislation and not in a minor amendment to a statutory instrument.

It is also noted that new Aged Care Quality Standards were introduced in the *Quality of Care Amendment (Single Quality Framework) Principles 2018.*[2] The relevant section of the Aged Care Quality Standards is Standard 8 — Organisational Governance which provides for:

Consumer outcome

(1) I am confident the organisation is well run. I can partner in improving the delivery of care and services

Organisation statement

(2) The organisation's governing body is accountable for the delivery of safe and quality care and services

Requirements

(3) The organisation demonstrates the following:

- consumers are engaged in the development, delivery and evaluation of care and services are supported in that engagement;
- the organisation's governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery;
- effective organisation wide governance systems relating to the following;
  - (i) information management;
  - (ii) continuous improvement;
  - (iii) financial governance;
  - (iv) workforce governance, including the assignment of clear responsibilities and accountabilities;
  - (v) regulatory compliance;
  - (vi) feedback and complaints;
- effective risk management systems and practice, including but not limited to the following;

[2] *Quality of Care Amendment (Single Quality Framework) Principles 2018* (Cth).

(i) managing high impact or high prevalence risks associated with the care of consumers;
(ii) identifying and responding to abuse and neglect of consumers;
(iii) supporting consumers to live the best life they can;

- where clinical care is provided – a clinical governance framework, including but not limited to the following;
  (i) antimicrobial stewardship;
  (ii) **minimising the use of restraint;** [emphasis added]
  (iii) open disclosure.

In terms of setting standards and an appropriate and accountable regulatory framework for the use of physical or chemical restraint, Quality Standard 8 is wholly inadequate. The standard makes a minimal reference to the use of restraint by merely requiring the clinical governance framework include minimising its use. Because the standard is so vague in its requirements around minimising the use of restraint, it is likely that it would be relatively easy for an aged care provider to satisfy this requirement with very little detail in any clinical governance framework. Consequently, in its current form the Quality Standard is unlikely to achieve much in terms of reducing or eliminating the use of restraint or any other positive outcomes for aged care residents in terms of responding to challenging behaviours.

Taking the above into account and considering section 15E's acknowledgement that Part 4A does not affect the operation of any law of a State or Territory in relation to restraint, the question must be asked, whether the Commonwealth Government actually has a legislative head of power to authorise restrictive practices in aged care.

The NDIS restrictive practices regime as a model

In their submissions, the Victorian Public Advocate and the Queensland Public Guardian both refer to the restrictive practices regimes for disability operating in their respective jurisdictions,[3] which support the operation of the National Disability Insurance Scheme while relying on decision-making under the respective State guardianship schemes. It is interesting to note, that under the NDIS, the Commonwealth has not legislated to authorise the use of restrictive practices, but has relied on the state and territory disability restrictive practices regimes, with complementary arrangements under state, territory and Commonwealth legislation to achieve this outcome.
I note and support the suggestion by the Queensland Public Guardian that consideration should be given by the Commonwealth to adopting a model equivalent to the Queensland disability restrictive practices statutory regime. In her submission, the Public Guardian stated:

> 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 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. (at p 11 of Public Guardian, Queensland submission.)

I also respectfully support the Queensland Public Guardian's recommendation to the Committee that it recommend the Commonwealth Government undertake 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.
Key characteristics of a human rights-compliant restrictive practices regime
I thought it would be of assistance to the Committee to also refer members to the recommendations of the ALRC in its final report for the Elder Abuse Inquiry, *Elder Abuse: A*

[3] Under the *Disability Act 2006* (Vic) and the *Guardianship and Administration Act 2000* (Qld) and the *Disability Services Act 2006* (Qld).

National Legal Response. In that report, the ALRC recommended that aged care legislation should regulate the use of restrictive practices in residential aged care and outlined some key characteristics of such a regime:

> **Recommendation 4–10** Aged care legislation should regulate the use of restrictive practices in residential aged care. Any restrictive practice should be the least restrictive and used only:
> (a) as a last resort, after alternative strategies have been considered, to prevent serious physical harm;
> (b) to the extent necessary and proportionate to the risk of harm;
> (c) with the approval of a person authorised by statute to make this decision;
> (d) as prescribed by a person's behaviour support plan; and
> (e) when subject to regular review.
> **Recommendation 4–11** The Commonwealth Government should consider further safeguards in relation to the use of restrictive practices in residential aged care, including:
> (a) establishing an independent Senior Practitioner for aged care, to provide expert leadership on and oversight of the use of restrictive practices;
> (b) requiring aged care providers to record and report the use of restrictive practices in residential aged care; and
> (c) consistently regulating the use of restrictive practices in aged care and the National Disability Insurance Scheme.[4]

The 2017 independent review of the national aged care quality regulatory processes, conducted by Ms Kate Carnell and Professor Ron Paterson[5] also recognised this gap in the legislation, making a recommendation to government to legislate to regulate the use of restrictive practices as follows:

> 7. Aged care standards will limit the use of restrictive practices in residential aged care
> i. Any restrictive practice should be the least restrictive and used only:
> a. as a last resort, after alternative strategies have been considered, to prevent serious physical harm;
> b. to the extent necessary and proportionate to the risk of harm;
> c. with the approval of a person authorised by statute to make this decision;
> d. as prescribed by a person's behaviour support plan; and
> e. when subject to regular review.
> ii. Approved providers must record and report the use of restrictive practices in residential aged care to the Aged Care Commission
> iii. Accreditation reviews will review the use of psychotropic agents
> iv. Chief Clinical Advisor must approve the use of antipsychotic medications for aged care residents.[6]

More recently (October 2018), the Standing Committee on Health, Aged Care and Sport released its *Report on the inquiry into the Quality of Care in Residential Aged Care Facilities in Australia*[7] which also recommended the Australian Government amend the *Aged Care Act* 1997 to legislate for the use of restrictive practices in residential aged care facilities.

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[4] Australian Law Reform Commission, *Elder Abuse-A National Legal Response,* Report No 131 (2017) 11.
[5] Carnell, Kate AO and Paterson, Ron ONZM, *Review of National Aged Care Quality Regulatory Processes*, October 2017.
[6] *Ibid*, Recommendation 7, p xii.
[7] Standing Committee on Health, *Aged Care and Sport, Report on the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia* (October 2018), Canberra Australia.

How the Quality of Care standards fall short of the ALRC recommended model

While any tightening of the standards of care around the use of physical and chemical restraint in residential aged care is supported, the amendment does not adopt many of the fundamental features of an accountable and transparent restrictive practices regulatory framework as recommended by the ALRC.

Some of the key features missing from the Australian Government's proposed new scheme include:

- the proposed scheme does not provide for the appointment of a formal independent decision-maker who is at arms-length from the provision of care to the person subject to the restrictive practice;
- there is no appeal process;
- there is no requirement that there should be regular reviews of the use of restrictive practices;
- there is no requirement that providers develop a behaviour support plan for the person which would guide the care provided to the person and decision-making and ensure the focus is on reducing and eliminating the use of restrictive practices;
- in the case of the use of chemical restraint, there is no requirement that the restrictive practices be applied for the least time necessary;
- there is no requirement that the restrictive practices used be proportionate to the risk of harm; and
- the proposed regime only requires that the consumer pose 'a risk of harm' which is a much lower threshold than the ALRC's recommendation that restrictive practices only be used to 'prevent serious physical harm'.

It is extremely concerning that the proposed regime provides for a doctor (most often a general practitioner), nurse practitioner or registered nurse to make decisions in relation to the use of restrictive practices, when most of these health practitioners will not have any formal training or recognised specialty in relation to the provision of clinical care in aged care or positive behaviour management.

This concern is further compounded by the fact that the health practitioners making the decisions also have an interest in the outcome of the decision, in terms of the management of the resident, the workloads of staff and the operation of the facility (because they also work there or provide services to the residents through an arrangement with the service provider). Decisions to prescribe medication to 'manage' residents who are displaying challenging behaviours will necessarily be influenced by considerations other than the rights of the residents and the immediate risk of harm to them or others. Those other considerations may include the views of management, the availability/numbers of staff and their skills in dealing with challenging residents, as well as convenience.

When decisions are being made to use chemical or other restraints on aged care residents by people who are not sufficiently independent of the provision of services, or trained in this type of decision-making, there is a risk that the decisions to use the restrictive practices may give too much weight to certain considerations or may take other, irrelevant, considerations into account, which will ultimately affect the quality and appropriateness of the decision.

Consent to the use of restrictive practices

Another key legal issue that arises from the proposed new Quality of Care Principles is that they make provision for the provider to obtain 'the informed consent of the consumer or the consumer's representative' to the use of restraint. (This consent is not required by the Principles in relation to the use of chemical restraint, apparently because it is a 'clinical' decision. Concerns relating to this approach are discussed further below.)

Across Australia, it is generally accepted that the law is unclear about whether a person's guardian or formal decision-maker can consent to the use of restrictive practices on a person for whom they are appointed to make decisions:

> ... absent specific legislative authorisation either through restrictive practices or coercive powers provisions in the legislation, questions remain about authorising restrictive practices through the guardianship system. This is despite the apparent widespread reliance on it, including with some apparent endorsement of this position by guardianship bodies.[8]

While guardians and formally appointed decision-makers, such as enduring attorneys for personal matters, are generally recognised as having the authority to consent to medical treatments for the person for whom they can make decisions, the law distinguishes between consent to medical treatment and consent to a restrictive practice. As noted above, this issue has been addressed in the disability space under the NDIS. However, it is particularly concerning that the Australian Government is proposing an approach to correct the current inadequacies of the law around the use of restrictive practices in residential aged care that relies on the consent of guardians and other substitute decision-makers when the law is uncertain about whether guardians can lawfully consent to these practices in each jurisdiction, and without any consultation with guardians/advocates and state and territory governments. Instead of providing legal clarity to protect the rights and interests of aged care consumers and those who would be giving consent to restrictive practices, the Minister's recent changes to provide for chemical and physical restraint only raise further legal questions and leave residents, substitute decision-makers and residential aged care staff in a legal limbo.

The problems associated with representatives' consent to the use of restrictive practices is compounded by the very informal 'representation' arrangements that are provided for under the *Aged Care Act 1997*. Under section 5 of the *Quality of Care Principles 2014,* other than under an enduring power of attorney or guardianship appointment, the following representative arrangements can be made:

- the consumer can nominate 'a person to be told about matters affecting the consumer';
- a person can nominate themselves to be 'a person to be told about matters affecting a consumer' and the approved provider 'is satisfied the person has a connection with the consumer' and is concerned for that person's safety, health and well-being;
- the person can be 'a partner, close relation or other relative of the consumer'; or
- it can be as relaxed as 'the person represents the consumer in dealings with the approved provider.'

It is unclear who can make the determination that the person can be regarded as the consumers' representative. However, again it seems wholly inappropriate that a person accepted as a 'representative' in most of the circumstances outlined under section 5 of the Principles, should also be authorising providers to physically restrain a person in aged care or be the person to be notified about the use of chemical restraint. It is difficult to envisage how most ordinary people trying to fulfil such a role could provide 'informed consent' to the use of restraint on the aged care consumer they are trying to support. Most members of the public confronted with such a decision would not know what questions to ask and would have great difficulty challenging the proposed use of the restrictive practice. Quite rightly, they would feel they did not have enough knowledge or authority to question or challenge the aged care provider or its medical or nursing staff.

There is the further concern under the current arrangements, also raised by the Queensland Public Guardian, of a risk that aged care providers will require a person's formal and other

[8] Kim Chandler, Ben White and Lindy Willmott, 'What role for adult guardianship in authorising restrictive practices?' (2017), *Monash University Law Review,* (Vol 43, No 2) p 496.

decision-makers (under the *Aged Care Act*) to provide a blanket consent to the use of restrictive practices before accepting a prospective resident into care. This could potentially occur even when there has not yet been an identified need for the use of restrictive practices for the resident. Considering the history of some aged care providers requiring enduring powers of attorney or guardianship appointments before accepting a resident into care, this response by aged care providers is a real possibility. Commonwealth legislation should prohibit such practices as a breach of residents' human rights.

Consent and the use of chemical restraint

The 'use of chemical restraint' provisions under the Quality of Care Principles also raises significant concerns. The definition of 'chemical restraint' under the provisions is deficient because it does not require that the behaviour that the chemical restraint is administered to influence or control, is causing harm to the person or others,

These problems are further compounded by the approach to consent in relation to chemical restraint. Section 15G(1)(c) of the recent amendment to the Quality of Care Principles proposes that the consumer's representative be informed 'before the restraint is used if it is practicable to do so' [emphasis added]. Such an approach is not consistent with usual medical practice about obtaining consent to treatment. It is unlawful to administer any medical treatment to a person without their consent (or the consent of their substitute decision-maker), except in an emergency.

I draw Committee members' attention to documents that have been filed with the Royal Commission into Aged Care Quality and Safety by the Australian Government and are posted on the Royal Commission website. In particular, I refer the Committee to a document by the Minister's Aged Care Clinical Advisory Committee titled, *Reducing the inappropriate use of chemical restraints in residential aged care: Options Paper* (Cth.1007.1007.03). In that document the Advisory Committee states:

> The Committee agreed that there was clearly a problem with the overuse of antipsychotic medications and benzodiazepines in RAC [residential aged care], noting that a small proportion (estimated at about 10%) of the current use was clearly justified in the treatment of (often pre-existing) mental illness and some rare, acutely psychotic, manifestations of dementia. Most of the inappropriate prescribing was in the context of behavioural and psychological symptoms of dementia (BPSD) … They expressed the strong view that any prescription of these drugs for BPSD should be limited, closely monitored by a multidisciplinary team and decreased or discontinued whenever possible. (p 1.)

The Advisory Committee Options Paper also noted that 'formal or implied consent is currently not commonly obtained by prescribing practitioners'.[9] Again, as noted above, the provision of medical treatment without the informed consent of the patient or the patient's decision-maker is unlawful unless in an emergency.

The approach to consent to the use of chemical restraint in aged care is inconsistent with the usual definition of informed consent used in the health sector and contained in the National Safety and Quality Health Service Standards:

> Informed consent: a process of communication between a patient and clinician about options for treatment, care processes or potential outcomes. This communication results in the patient's authorisation or agreement to undergo a specific intervention or participate in planned care. The communication should ensure that the patient has an understanding of the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.[10]

[9] Options Paper, at p 5.
[10] National Safety and Quality Health Service Standards, Australian Commission on Safety and Quality in Health Care.

Clearly, aged care residents have not been receiving medical care and treatment, including the administration of medication as chemical restraint, in accordance with this definition of medical treatment. Not only is it clear that medical practitioners prescribing these medications to chemically restrain people in residential aged care have not been having these types of conversations with the resident/patient or their decision-makers, it would appear on the advice of the Aged Care Minister's Clinical Advisory Committee and the evidence before the Royal Commission, that medical practitioners are routinely prescribing antipsychotics and benzodiazepines without obtaining any consent, formal or implied.

The concern with the proposed new chemical restraint provisions under section 15G of the Quality of Care Principles, is that they appear to be suggesting to medical practitioners that they can prescribe and administer medications without informed consent and transfer all responsibility for the notification of the residents' representatives, as well as documenting the basis for the treatment and monitoring the effects of the treatment on the residents, to the aged care provider. This approach is dangerous and inappropriate and does not hold medical practitioners properly and professionally accountable for their prescribing practices and the treatment of their elderly patients in residential aged care.

Considering what we now know about the problem of physical and chemical restraint in aged care, it is reasonable to anticipate that the recent amendments to the Aged Care Quality Principles in relation to chemical restraint are unlikely to achieve the stated objective of reducing chemical restraint and may actually result in an increase in inappropriate prescribing practices.

It is difficult to understand the basis on which this treatment of older members of the Australian community can be justified. These restrictive practice provisions amount to clear breaches of the human rights of people in residential aged care, including their rights to dignity and respect and quality health care.

We all have the fundamental right to be free from physical restrictions and to bodily integrity. These rights do not diminish with age or infirmity. The Australian community should rightly be extremely concerned about the poor treatment and practices that we have allowed to proliferate in parts of the aged care sector. These recent amendments are likely to exacerbate these problems.

I respectfully request the Committee recommend disallowance of the Quality of Care Amendment (Minimising the Use of Restraints) Principle 2019.

Yours sincerely

Mary Burgess
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