Office of the Public Advocate

11 July 2019

The Secretary,
Parliamentary Joint Committee on Human Rights,
Parliament House,
Canberra ACT 2600

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

Dear Secretary,

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

The Quality of Care principles to minimise the use of restraint in aged care were made on 2 April 2019 and commenced on 1 July 2019. When the Committee is considering these principles, I ask that it takes into account the matters set out below.

The legislative instrument used to introduce a scheme of authorisation

I am advised that, at common law, the use of restraint, whether physical or chemical, would constitute a criminal offence if it is not properly authorised. I understand that there are exceptions recognised in common law that restraint can be used lawfully in an emergency or out of necessity until proper, lawful, authorisation is obtained.

The use of restraint seriously affects a person's human and legal rights and its use must be justified in each instance.

The Victorian Law Reform Commission considered such restrictions on liberty in its report on Guardianship in 2012[1].

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. I cannot help but compare how restraint is regulated in the disability sector under Victoria's *Disability Act 2006* and, since 1 July 2019 in Victoria, under the NDIS.

[1] See Chapter 15. Recently the NSW Law Reform Commission reviewed Guardianship and reported on the issue of restrictive practices in Chapter 12.

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Substitute decision-making regime introduced

Where a resident in aged care is unable to provide consent to restraint, the minimisation of restraint principles introduce two types of substitute decision-making.

I draw the Committee's attention to Article 12 of the UN *Convention on the Rights of Persons with Disabilities* and the *General comment No. 1 (2014) on Article 12*. The restraint minimisation principles do not reflect an awareness of these documents and human rights principles. I draw the Committee's attention to Victoria's *Guardianship and Administration Act 2019* and the *Medical Treatment Planning and Decisions Act 2016* that maintain a system of substitute decision making but take these UN Instruments into account.

Physical restraint

In the case of physical restraint, the substitute decision-making regime involves the informed consent of the consumer's representative.

The Quality of Care principles set out who can be such a representative. It may be a person nominated by the consumer. But it could be a person who nominates themselves as 'a person to be told about matters affecting a consumer'. The Quality of Care principles indicate (but do not determine) that this could be a partner, a close relative or other relative of the consumer. It could also be a person who holds an enduring power of attorney, or an appointed guardian to deal with the consumer's affairs. It could be the person who 'represents the consumer in dealings with the organisation'.

I make the following observations about the list of people who can fulfil this role on behalf of the resident.

1. It doesn't establish a hierarchy of persons should there be a dispute as to who fulfils the role. It is my office's experience that these matters are regularly contested.
2. It permits people to nominate themselves, but does not provide the resident with any right to veto the person so nominating.
3. The terms like 'partner' and 'close relation' are defined in the Aged Care Act 1997, but in the division related to "What is the amount of residential care subsidy". This is a very different context from determining the use of restraint. The definitions are not written into the Quality of Care principles. "Relative" is not defined.

4. It doesn't distinguish between types of powers of attorney. For example, in Victoria a person can be an attorney for financial matters, but this would not seem a relevant qualification for consenting to the use of physical or chemical restraint. In Victoria a person could appoint a medical treatment decision maker, but restraint would not qualify as medical treatment under Victoria's *Medical Treatment Planning and Decisions Act 2018*. Also in Victoria a person can appoint an attorney for personal matters[2]. This appointee may have sufficient authority, but that is not apparent from the list of examples contained in the definition of 'personal matters'.
5. It doesn't differentiate between guardianship appointments. I may be appointed a resident's guardian to make decisions about their accommodation, but I do not see that I would be, thereby, entitled to make decisions that they be physically restrained. Unless a guardian had specific powers to agree to the use of physical restraint under Victorian law, I do not see that they would be authorised to be the resident's representative to provide informed consent to physical restraint. Subsection (3) of the definition of 'representative' does not make such limitation apparent.
6. It permits the representative to be a person 'who represents the consumer in dealings with the organisation'. An advocate may represent a person in dealings with an organisation but have no formal authority to make decisions for that person.

It is not clear to me whether it is intended that the restraint minimisation principles empower representatives to consent to physical restraint, or merely acknowledge these persons may provide consent if they have such power through another source of authority, such as guardianship, a power of attorney or the common law. If the principles operate to authorise the representatives, it is not clear to me how this can be achieved by mere regulation.

For comparison, I draw your attention to section 55 of Victoria's *Medical Treatment Planning and Decisions Act 2016* for the list of persons in Victoria who can make medical treatment decisions for a person who lacks decision-making capacity.

I note the modest definition of 'physical restraint' that is used in the restraint minimisation principles. It is helpful to compare this with the definition used in the *NDIS (Restrictive Practices and behaviour Support) Rules 2018* –

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[2] *Powers of Attorney Act 2014*

physical restraint, which is the use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person.

In the NDIS Rules, physical restraint is differentiated from seclusion, chemical restraint, mechanical restraint and environmental restraint.

The NDIS provides a far more robust approach to the use of restraint and far stronger safeguards, including authorisation by the State of Victoria regarding Victorian residents. I am perplexed that there is not an equally rigorous and robust approach in aged care.

Chemical restraint

An approved 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 restraint has been recorded in the resident's care and services plan, and
- the resident's representative is informed before the restraint is used.

It is regrettable we have introduced a system that the decision to use chemical restraint is made by a medical or nurse practitioner. Until the commencement of the *Medical Treatment Planning and Decisions Act 2016* on 12 March 2018, Victoria had a system whereby a medical practitioner could consent to the administration of a pharmaceutical drug for the purpose and in accordance with the dosage level recommended by the registered practitioner or as recommended in the manufacturer's instructions[3]. Under this system chemical restraint could be provided on the say so of a medical practitioner.

The Victorian Law Reform Commission rejected this approach in its 2012 report on Guardianship[4]. The *Medical Treatment Planning and Decisions Act 2014* is more aligned with the Victorian Law Reform Commission's approach, but this Act does not regulate the use of chemical restraint where a person is unable to consent to it.

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[3] *Guardianship and Administration Act 1986* s3 definition of *medical or dental treatment* – see (g)
[4] See Chapter 13

In residential aged care facilities the visiting medical practitioners have a divided loyalty between the facility and their patient. The only independent safeguard in the restraint minimisation principles is the role of the representative who is merely informed about the use of chemical restraint. There is no mechanism for objection or challenge.

Summary

I am pleased that the Government has acted to regulate the use of restraint in residential aged care facilities as there has been a regulatory gap for far too long.

However, I fear the restraint minimisation principles are -

- inconsistent with the human rights of the affected persons
- of questionable legality given a person's rights at common law, and the extraordinary authority they seem to bestow on the representative and medical and nurse practitioners
- poorly executed in terms of definitions and the hierarchy of representatives, and
- lacking safeguards such as those thought necessary for participants in the NDIS who are subject to regulated restrictive practices.

The Australian Newspaper reported in October 2017 that 40% of people in aged care facilities have no visitors[5]. Who will represent these people if they are subject to physical and chemical restraint? To whom will nurse and medical practitioners inform of their decisions to chemically restrain? I remain troubled that the restraint minimisation principles are inadequate to offer real human rights protections.

I would be pleased when the Parliamentary Joint Committee on Human Rights scrutinised the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* it considers the issues I have raised on behalf of people with disabilities in Victoria.

Yours faithfully,

(Dr) Colleen Pearce
Public Advocate

[5] The Australian 25 October 2017