Parliamentary Joint Committee on Human Rights

Inquiry report

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

13 November 2019

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PO Box 6100
Parliament House
Canberra ACT 2600

Phone: 02 6277 3823
Fax: 02 6277 5767

Email: human.rights@aph.gov.au
Website: http://www.aph.gov.au/joint_humanrights/

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1 The human rights committee secretariat is staffed by parliamentary officers drawn from the Department of the Senate Legislative Scrutiny Unit (LSU), which usually includes two principal research officers with specialised expertise in international human rights law. LSU officers regularly work across multiple scrutiny committee secretariats.

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Glossary

Aged Care Act	*Aged Care Act 1997* (Cth)
CAT	Convention against Torture and other Cruel, Inhuman, Degrading Treatment or Punishment
CRPD	Convention on the Rights of Persons with Disabilities
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
The instrument	Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019
NDIS	National Disability Insurance Scheme
NDIS rules	National Disability Insurance Scheme (Restrictive Practice and Behaviour Support) Rules 2018
UN	United Nations

Recommendations

Recommendation 1

4.26 In light of the above concerns, the committee recommends, at a minimum, that:

- **the instrument be amended to include a note to clarify that other laws prohibit the use of both physical and chemical restraint without prior informed consent; and**
- **detailed amendments are made to the explanatory materials accompanying the instrument, to clarify how the instrument interacts with state and territory laws, in particular regarding the authorisation of substitute decision-making and the continued obligations for prescribers to exhaust alternative options and obtain informed consent prior to the use of chemical restraint.**

Recommendation 2

4.27 The committee also recommends that the minister undertakes extensive consultation with relevant stakeholders to work towards better regulating the use of restraints in residential aged care facilities, in particular including:

- **an explicit requirement to exhaust alternatives to the use of restraint, including preventative measures and that restraint be used as a last resort (noting the approach taken by the National Disability Insurance Scheme rules);**
- **obligations to obtain or confirm informed consent prior to the administration of chemical restraint;**
- **improved oversight of the use of restraints in aged care facilities; and**
- **mandatory reporting requirements for the use of all types of restraint.**

Chapter 1

Background

Initiation of inquiry

1.1 The Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 [F2019L00511] (the instrument) came into force on 1 July 2019. The instrument seeks to regulate the use of physical restraints and chemical restraints by approved providers of residential aged care and short-term restorative care in a residential setting.

1.2 The statement of compatibility accompanying the instrument states that by regulating the use of these practices, the instrument promotes the right to health and the right to protection from exploitation, violence and abuse and assists in promoting the protection of the health and well-being of recipients of aged care services.[1] By emphasising the 'need to take a person centred approach' which preserves the human rights of a person, the instrument seeks to address that the use of chemical or physical restraints 'in some cases, may subject the person to an increased risk of physical and/or psychological harm'.[2]

1.3 Appropriate regulation and oversight of the use of restraints may be capable of promoting these identified rights; however: prescribing the circumstances in which physical or chemical restraints may be used in aged care settings has the possibility of engaging and potentially limiting a number of human rights. These include Australia's absolute obligation not to subject persons to torture, cruel, inhuman or degrading treatment or punishment; the rights to health, privacy and liberty; the right to equality and non-discrimination and the rights of persons with disabilities (these are not specifically addressed by the statement of compatibility).

1.4 The mandate of the Parliamentary Joint Committee on Human Rights (the committee) under paragraph 7(a) of the *Human Rights (Parliamentary Scrutiny) Act 2011* is to examine all bills and legislative instruments that come before either House of the Parliament for compatibility with human rights[3] and to report to both

1 Statement of compatibility, pp. 10-11.

2 Statement of compatibility, p. 10.

3 'Human rights' is defined in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011* to mean the rights and freedoms recognised or declared by seven international instruments: International Convention on the Elimination of all Forms of Racial Discrimination; International Covenant on Economic, Social and Cultural Rights; International Covenant on Civil and Political Rights; Convention on the Elimination of All Forms of Discrimination Against Women; Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; Convention on the Rights of the Child; and Convention on the Rights of Persons with Disabilities.

Houses of the Parliament on that issue. As such, the committee is required to examine the instrument as part of its scrutiny of legislative instruments. The committee received correspondence from Human Rights Watch and the Office of the Public Advocate (Victoria) asking it to consider a number of human rights concerns in relation to the instrument, including the prohibition against cruel, inhuman, or degrading treatment, the right to health, and the rights of persons with disabilities.[4]

1.5 Following this, on 29 July 2019 the Parliamentary Joint Committee on Human Rights resolved to conduct a short inquiry into the instrument, as part of its function of examining legislative instruments for compatibility with human rights.

The hearing

1.6 The committee held a one day public hearing in Sydney on Tuesday 20 August 2019 in relation to the instrument. Officials from the Department of Health attended the hearing. A full list of witnesses who appeared at the hearing is at Appendix 2,[5] and the Hansard transcript is available on the committee website.[6] The committee received 17 written submissions as listed at Appendix 1.[7]

1.7 Following the hearing the committee sought further information from the Department of Health.[8] The department provided a response on 10 September 2019.[9]

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4 Letter from Human Rights Watch, 23 May 2019, and Office of the Public Advocate (Victoria), 11 July 2019 (see Appendix 1), available at: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Human_Rights/QualityCareAmendment.

5 Witnesses to the hearing were invited by the committee in order to benefit from a broad range of perspectives from relevant experts and stakeholders.

6 In this report, references to the *Hansard* are to the proof transcript. Page numbers may vary between proof and official transcripts.

7 The committee did not call for submissions to this inquiry, but accepted any relevant submissions that were provided.

8 Letter from the Parliamentary Joint Committee on Human Rights to the Secretary of the Department of Health, 28 August 2019 (see Appendix 3), available at: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Human_Rights/QualityCareAmendment.

9 Letter from the Department of Health to the Parliamentary Joint Committee on Human Rights, 10 September 2019 (see Appendix 3), available at: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Human_Rights/QualityCareAmendment. A further two pieces of correspondence were received, from the Public Advocate (Queensland) and the Public Advocate (Victoria), in response to the Department of Health's response to the committee's questions. See Letter from the Public Advocate (Queensland), 12 September 2019, and letter from the Public Advocate (Victoria), 17 September 2019 (see Appendix 3), available at: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Human_Rights/QualityCareAmendment/Additional_Documents.

1.8 On behalf of the committee, Senator McKim placed a protective notice of motion to disallow the instrument in the Senate on 16 September 2019, to extend the period by which the instrument is subject to disallowance by a further 15 sitting days. The disallowance procedure is the primary mechanism by which the Parliament may exercise control over delegated legislation. The placing of the protective notice of motion to disallow ensured continued parliamentary control over the instrument pending completion of the committee's inquiry.

Structure of the report

1.9 The report contains four chapters, as follows:

- Chapter 1 sets out the introduction and background to the inquiry;
- Chapter 2 discusses the instrument and the legal background to the regulation of physical and chemical restraints, including the interaction with state and territory legislation;
- Chapter 3 discusses the issues raised by submitters and witnesses to the inquiry, and the responses received from the Department of Health; and
- Chapter 4 considers the human rights concerns and legal issues raised by the instrument and sets out the committee's recommendations.

Acknowledgements

1.10 The committee acknowledges and thanks the organisations and individuals who assisted with and contributed to the inquiry by making submissions, giving evidence at the public hearing and providing additional information.

Chapter 2

The instrument

2.1 On 17 January 2019, the Hon. Ken Wyatt, the then Minister for Senior Australians and Aged Care announced new regulations to prevent the excessive use of physical and chemical restraints in aged care. Consultation with a 'Key Stakeholder Working Group', which consisted of industry and consumer groups, took place in person in February 2019 and by teleconference on 4 and 18 March 2019.[1]

2.2 The Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 [F2019L00511] (the instrument) was registered on the Federal Register of Legislation on 2 April 2019 and tabled in the House of Representatives on 3 April 2019 and in the Senate on 2 July 2019. The instrument came into force on 1 July 2019.

2.3 The instrument seeks to regulate the use of 'physical restraints' and 'chemical restraints' by approved providers of residential care and short-term restorative care in a residential care setting. 'Restraint' is defined in section 4 to mean 'any practice, device or action that interferes with a resident's ability to make a decision or restricts a resident's free movement.'[2]

Regulation of physical restraints

2.4 'Physical restraint' is defined in section 4 to mean 'any restraint other than a chemical restraint or the use of medication prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.'[3]

2.5 This might, for example, include the use of bed rails, lap belts, restraining chairs, table overlays, hand mitts and vests; the use of physical force, such as clasping someone's hands together; or confinement by removing a person's walking aid, or closing and/or locking a door to prevent a person from leaving a particular area.

2.6 Section 15F of the instrument provides that an approved provider must not use a physical restraint unless:

(a) an approved health practitioner who has day-to-day knowledge of the resident has:

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1 Department of Health, Answers to Questions on Notice No. 2, 10 September 2019.

2 Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019, section 4.

3 Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019, section 4.

(i) assessed the resident as posing a risk of harm to the resident or any other person, and as requiring the restraint; and

(ii) documented the assessment, unless the use of the restraint is necessary in an emergency;

(b) alternatives to restraint have been used for the resident to the extent possible (and the alternatives to restraint have been documented, unless the use of the restraint is necessary in an emergency);

(c) the restraint is the least restrictive form of restraint possible; and

(d) the approved provider has the informed consent of the resident or their representative to the use of the restraint, unless the use of the restraint is necessary in an emergency.[4]

2.7 Where a physical restraint is used, the approved provider must:

(a) if the restraint is used in an emergency, document the matters as soon as practicable after the restraint starts to be used;

(b) if the restraint is used without consent, inform the resident's representative as soon as practicable after the restraint starts to be used;

(c) ensure the resident's care and services plan identifies: the resident's behaviours that are relevant to the need for the restraint; the alternatives to restraint that have been used (if any); the reasons the restraint is necessary; and the care to be provided to the resident in relation to the resident's behaviour;

(d) use the restraint for the minimum time necessary; and

(e) while the resident is subject to the restraint, regularly monitor them for signs of distress or harm and regularly monitor and review the necessity for the restraint.[5]

Definition of representative

2.8 As paragraph 15F(1)(e) provides that physical restraints cannot be used unless the approved provider has the informed consent of the consumer or their representative, the definition of 'representative' is relevant to understanding how the provisions apply. The pre-existing definition of 'representative' in section 5 of the Quality of Care Principles 2014 applies, to include:

4 Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019, subsection 15F(1).

5 Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019, subsection 15F(2).

(a) a person nominated by the resident as a person to be told about matters affecting the resident; or

(b) a person who nominates themselves as a person to be told about matters affecting a resident; and who the relevant organisation is satisfied has a connection with the resident and is concerned for the safety, health and well‑being of the resident.[6]

2.9 A person 'has a connection with a resident' if:

(a) the person is a partner, close relation or other relative of the resident;

(b) the person holds an enduring power of attorney given by the resident;

(c) the person has been appointed by a state or territory guardianship board (however described) to deal with the resident's affairs; or

(d) the person represents the resident in dealings with the organisation.[7]

2.10 However, the provision defining 'representative' also states that nothing in that section is intended to affect the powers of a substitute decision-maker appointed for a person under a law of a state or territory.[8]

Regulation of chemical restraints

2.11 'Chemical restraint' is defined in section 4 of the instrument to mean:

> a restraint that is, or that involves, the use of medication or a chemical substance for the purpose of influencing a person's behaviour, other than medication prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.[9]

2.12 This might, for example, include the use of psychotropic medications such as antipsychotics, benzodiazepines or antidepressants to sedate or subdue residents with dementia.

2.13 Section 15G of the instrument provides that an approved provider must not use a chemical restraint in relation to a resident unless:

(a) a medical practitioner or nurse practitioner has assessed the resident as requiring the restraint and has prescribed the medication the use of which is, or is involved in, the restraint;

(b) the practitioner's decision to use the restraint has been recorded in the resident's care and services plan; and

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6 Quality of Care Principles 2014, subsection 5(1).

7 Quality of Care Principles 2014, subsection 5(2).

8 Quality of Care Principles 2014, subsection 5(3).

9 Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019, section 4.

(c) the resident's representative is informed before the restraint is used if it is practicable to do so.[10]

2.14 Where a chemical restraint is used, the approved provider must:

(a) inform the resident's representative as soon as practicable after the restraint starts to be used (if not already informed); and

(b) ensure the resident's care and services plan identifies: the resident's behaviours that are relevant to the need for the restraint; the alternatives to restraint that have been used (if any); the reasons the restraint is necessary (if known by the approved provider); and the information (if any) provided to the practitioner that informed the decision to prescribe the medication; and

(c) regularly monitor the resident for signs of distress or harm while using the restraint and provide information to the practitioner regarding use of the restraint.[11]

Interaction with state and territory legislation

2.15 Section 15E of the instrument provides that the new provisions do not 'affect the operation of any law of a State or Territory in relation to restraint'. The Explanatory Statement notes that '[p]roviders, medical practitioners, nurses and other health professionals must comply with the other laws in the applicable State and Territory which regulate restraint.'[12] However, it does not set out what those laws are.

Legal background to the regulation of restraints

2.16 Restrictive practices are regulated under a complex interplay of general law, and Commonwealth, state and territory laws and guidelines, as summarised below.

Obligations on residential aged care homes and approved providers

2.17 There is existing Commonwealth legislation that regulates the obligations of approved providers, some of which are relevant to the use of restraint. The principal Commonwealth legislation relating to aged care is the *Aged Care Act 1997* (Cth) (Aged Care Act). Under this Act, the Commonwealth provides aged care funding subsidies to approved providers. The Aged Care Act identifies a range of standard of care principles which approved providers must comply with to secure and retain funding. These are further elaborated in subordinate legislation (the Quality of Care

10 Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019, subsection 15G(1).

11 Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019, subsection 15G(2).

12 Explanatory statement, p. 5.

Principles 2014), made by the Minister for Health pursuant to section 96(1) of the Aged Care Act.

2.18 Since 2018, the regulatory regime established under the Aged Care Act has been supplemented by the establishment of the Aged Care Quality and Safety Commission.[13] The focus of the Aged Care Quality and Safety Commission is on compliance with accreditation standards within each residential aged care home, whereas that of the Department is on compliance by the approved provider (that is, the corporation or organisation that owns the aged care homes).[14]

2.19 Failure by approved providers to meet the responsibilities set out in section 54-1 and elaborated in the Principles can lead to the imposition of sanctions by the secretary that affect the status of approvals and similar decisions under the Aged Care Act (and therefore may affect amounts of subsidy payable to an approved provider).[15] The paramount consideration with respect to the imposition of sanctions is whether the non-compliance threatens or would threaten the health, welfare or interests of current and future care recipients.[16]

2.20 The Quality of Care Principles 2014 also require that approved providers adopt systems to:

(a) identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines;[17]

(b) effectively manage challenging behaviours;[18] and

(c) safely and correctly manage medication.[19]

2.21 As of 1 July 2019, approved providers are required to report all uses of physical restraint to the Aged Care Quality and Safety Commission under the National Aged Care Quality Indicator Program.[20]

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13 Under the *Aged Care Quality and Safety Commission Act 2018* (Cth).

14 *Aged Care Act 1997* (Cth) (Aged Care Act), section 8-1. The responsibilities of aged care providers are set out in Chapter 4, section 54-1 of the Aged Care Act. The detail of these responsibilities is elaborated in Principles made by the Minister for Health under section 96-1 of the Aged Care Act. Note that the Aged Care Legislation Amendment (New Commissioner Functions) Bill 2019, introduced on 16 October 2019, seeks to transfer additional aged care regulatory functions of the secretary of the department to the Aged Care Quality and Safety Commissioner.

15 Aged Care Act, section 65-1.

16 Aged Care Act, section 65-2.

17 Quality of Care Principles 2014, schedule 2, part 1, item 1.2.

18 Quality of Care Principles 2014, schedule 2, part 1, item 2.13.

19 Quality of Care Principles 2014, schedule 2, part 1, item 2.7.

20 Aged Care Legislation Amendment (Quality Indicator Program) Principles 2019, schedule 1.

2.22 The Aged Care Quality and Safety Commission's 2019 *Results and Processes Guide*, which is designed to help approved providers understand their obligations under the Quality of Care Principles 2014 and the Aged Care Act, states that restraint must be used as a last resort,[21] and that approved providers must regularly review medication with a pharmacist or medical officer.[22]

2.23 The Aged Care Quality and Safety Commission's *Guidance and Resources for Providers to support the Aged Care Quality Standards 2019* also include guidance on compliance with standards concerning minimisation of restraint. These new standards also require providers to demonstrate:

- that residents are supported to exercise choice and independence;[23]
- a service environment that enables consumers to move freely indoors and outdoors;[24] and
- a clinical governance framework that includes minimising the use of restraint.[25]

2.24 The explanatory statement states that the instrument promotes a 'restraint-free environment' as 'a basic human right for all consumers'. It notes:

> Existing guidance on best practice is set out in the Decision Making Tool: Supporting a Restraint-Free Environment (Decision Making Tool). The Decision Making Tool notes the use of restraint should always be the last resort and viewed as a temporary solution to any behaviour causing concern. Additionally, its use should only be considered after exhausting all reasonable alternative options and be informed by a comprehensive assessment of a consumer and their interactions.[26]

2.25 However, the committee notes that this Guidance material has no force of law and does not form part of the Quality Standards.

Obligations on health practitioners

Health Practitioner Regulations National Law Act 2009

2.26 All Australian states and territories have implemented legislation consistent with the *Health Practitioner Regulations National Law Act 2009* (QLD) (National Law

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21 Aged Care Quality and Safety Commission, *Results and Processes Guide* (2019) pp. 66-67.

22 Aged Care Quality and Safety Commission, *Results and Processes Guide* (2019) p. 47.

23 Aged Care Quality and Safety Commission, *Guidance and Resources for Providers to support the Aged Care Quality Standards* (2019), p. 4 (Standard 1(2)(b)).

24 Aged Care Quality and Safety Commission, *Guidance and Resources for Providers to support the Aged Care Quality Standards* (2019), pp 93, 99-101 (Standard 5(3)(b)(ii)).

25 Aged Care Quality and Safety Commission, *Guidance and Resources for Providers to support the Aged Care Quality Standards* (2019), pp. 132, 148 (Standard 8(3)(e)(ii)).

26 Explanatory Statement, p. 2.

Act), which provides for the regulation and accreditation of health practitioners.[27] This legislation provides for the establishment and functions of National Boards, and state or territory Boards, which are responsible for the registration and accreditation standards for health practitioners;[28] for monitoring and oversight;[29] and for the cancellation or suspension of registration.[30] The legislation also sets out the obligations of health practitioners;[31] imposes mandatory obligations on health practitioners, employers and education providers to report notifiable conduct;[32] and provides for voluntary notifications of concerns about practitioners.[33]

2.27 Health care workers, including those who are not registered (such as personal care workers), are also regulated by a national code of conduct (the Code), which explicitly requires that they 'must ensure that [prior] consent appropriate to that treatment or service has been obtained and complies with the laws of the jurisdiction'.[34]

2.28 Implementation of the Code rests with individual states and territories. Its manner of implementation differs from jurisdiction to jurisdiction.[35]

2.29 Although it does not constitute legislation, professional practice guidelines and codes assist with the interpretation of the obligations of health practitioners and health care workers. For example, the Royal Australian and New Zealand College of Psychiatrists Professional Practice Guideline 10 provides, amongst other things, that

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27 Australian Health Practitioner Regulation Agency, *What we do: Legislation*, at: https://www.ahpra.gov.au/About-AHPRA/What-We-Do/Legislation.aspx.

28 *Health Practitioner Regulations National Law Act 2009* (QLD) (National Law Act), Parts 5 & 6.

29 National Law Act, section 163-167.

30 National Law Act, section 156.

31 National Law Act, sections 128-132.

32 National Law Act, sections 141-143.

33 National Law Act, sections 144-147.

34 Council of Australian Governments Health Council Communique, *A National Code of Conduct for Health Care Workers*, 2015, Code 2 (the Code).

35 In Queensland, for example, the Code became effective from 1 October 2015 and is a prescribed conduct document under section 5 of the Health Ombudsman Regulation 2014. As a result, the Code may be taken into consideration by a person when making a decision under the Act about what constitutes appropriate conduct or practice for a health service provider to provide, or what is an appropriate way for a health service provider to provide a service. In NSW, the Code is set out in Schedule 3 of the Public Health Regulation 2012, made under the *Public Health Act 2010* (NSW). Section 99 of the Public Health Regulation 2012 provides that the Code is prescribed under section 100 of the Public Health Act as a code of conduct for the provision of health services. South Australia implemented the National Code of Conduct for Certain Health Care Workers in 18 March 2019. Health care workers who do not fall within the jurisdiction of the Australian Health Practitioner Regulation Agency (AHPRA) now have to comply with the Code and display certain information where they practise.

'[f]rom the outset…behavioural interventions should always be used prior to considering the use of any class of psychotropic medications for BPSD [Behavioural and Psychological Symptoms of Dementia] management'.[36] It also provides:

> Use of antipsychotic medications is recommended when BPSD are psychotic in nature, unresponsive to psychosocial interventions or there is a severe and complex risk of harm (Burns et al., 2012). Conversely, antipsychotic medications are not recommended and are unlikely to be effective in certain symptoms such as wandering, undressing, inappropriate voiding, verbal aggression or screaming.[37]

Commonwealth health law

2.30 There are also a number of obligations that apply to health practitioners under Commonwealth law. For example, to monitor compliance with the *Health Insurance Act 1973* (Cth) (Health Insurance Act), the Commonwealth Department of Health administers the Practitioner Review Program, which 'monitors Medicare servicing data and Pharmaceutical Benefits Scheme (PBS) prescribing data to identify and examine variations which may be indicative of possible inappropriate practice'.[38] If it appears that a practitioner may have engaged in an inappropriate practice, this could result in a request to the Director of Professional Services Review to review the provision of services. Under section 82 of the Health Insurance Act, a practitioner engages in 'inappropriate practice' if the relevant conduct would be unacceptable to the general body of relevant medical practitioners,[39] or 'if the circumstances in which some or all of the services were rendered or initiated constitute a prescribed pattern of services',[40] as defined in section 82A.

2.31 In relation to the prescription and use of chemical restraints, the *Therapeutic Goods Act 1989* (Cth) regulates the prescription, supply and administration of medicine approved for sale under the Australian Register of Therapeutic Goods.

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36 The Royal Australian and New Zealand College of Psychiatrists Professional Practice Guideline 10 (Antipsychotic medications as a treatment of behavioural and psychological symptoms of dementia), August 2016.

37 The Royal Australian and New Zealand College of Psychiatrists Professional Practice Guideline 10 (Antipsychotic medications as a treatment of behavioural and psychological symptoms of dementia), August 2016.

38 Department of Health, *Practitioner Review Program* (2018) at: https://www1.health.gov.au/internet/main/publishing.nsf/Content/practitioner-review-program.

39 *Health Insurance Act 1973*, subsections 82(1)(a) to 82(1)(d).

40 Under subsections 82(1B) to 82(1D) of the *Health Insurance Act 1973*, the conduct in question will not constitute a prescribed pattern of services if a Committee could reasonably conclude that, on that day, exceptional circumstances (including but not limited to circumstances that are prescribed by regulations to be exceptional) existed that affected the rendering or initiating of the services.

Further state and territory legislation regulates the supply and administration of medicines.[41]

Assault and trespass

2.32 At common law, a physical assault occurs where a person intentionally or recklessly causes unlawful force to be applied to the body or clothing of another.[42] This common law position is substantially reproduced by statute in the Northern Territory,[43] Queensland,[44] South Australia,[45] Tasmania[46] and Western Australia,[47] and in Victoria in relation to certain specified assault offences.[48] In all jurisdictions, there must be an absence of consent by the victim to the force used by the offender, and consent can be used as defence.[49] An assault against the person, as well as being a criminal offence, would also be a ground to make out a civil law action of trespass against the person.

2.33 As a result, health professionals must obtain the prior informed consent of a patient before carrying out any medical treatment, including the use of a restraint, except in the case of an emergency.[50] The common law doctrine of necessity can be used to justify interventions without consent.

State and territory guardianship law

2.34 State and territory legislation determines who can provide lawful consent to medical treatment on behalf of another, and regulates when and how this power can

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41 Royal Commission into Aged Care Quality and Safety, *Restrictive Practices in Residential Aged Care in Australia - Background Paper 4* (May 2019) p. 17 citing, for example, *Medicines and Poisons Act 2014* (WA); *Poisons and Therapeutic Goods Act 1966* (NSW).

42 *Fagan v Cmr of Metropolitan Police* [1969] 1 QB 439*; R v Gabriel* (2004) 182 FLR 102.

43 *Criminal Code Act 1983* (NT), subsection 187(a) (application of force to a person).

44 *Criminal Code Act 1899* (QLD), subsection 245(1) (strikes, touches or moves or otherwise applies force of any kind to the person of another).

45 *Criminal Law Consolidation Act 1935* (SA), subsection 20(1)(a) (intentionally applies force), and subsection 20(1)(b) (intentionally makes physical contact with the victim knowing the victim might reasonably object to the contact in the circumstances).

46 *Criminal Code Act 1924* (TAS), subsection 182(1) (applying force to the person of another).

47 *Criminal Code Act Compilation Act 1913* (WA)*,* section 222 (strikes, touches or moves or otherwise applies force of any kind to the person of another).

48 *Crimes Act 1958* (VIC), subsection 31(2) defines assault to include the application of force by a person to the body of, or to clothing worn by, another person which results in the infliction of bodily injury, pain, discomfort, damage, insult or deprivation of liberty.

49 See, for example, *Fagan v Cmr of Metropolitan Police* [1969] 1 QB 439; *R v Gabriel* (2004) 182 FLR 102. As to the statutory definitions, see: *Criminal Code Act 1983* (NT), subsection 187(a); *Criminal Code Act 1899* (QLD), subsection 245(1); *Criminal Law Consolidation Act 1935* (SA), subsections 20(1), 22(1); *Criminal Code Act 1924* (TAS), subsection 182(4); *Criminal Code Act Compilation Act 1913* (WA)*,* section 222 (or with consent obtained by fraud).

50 *Rogers v Whitaker* (1992) 175 CLR 479.

be exercised.[51] This legislation appears to establish two tests that substitute decision-makers must apply before exercising their powers:

- the best interests test, which requires them to balance the benefit to the patient against the risks of the proposed treatment; and/or
- the substituted judgment test, which requires them to make a decision that is consistent with what the person would have decided if they had the capacity to do so. (In applying this test, a substitute decision-maker may rely on evidence such as advance care directives, religious beliefs and previous history of treatment.)[52]

Obligations on National Disability Insurance Scheme providers

2.35 The use of restraints by National Disability Insurance Scheme (NDIS) providers is regulated by the National Disability Insurance Scheme (Restrictive Practice and Behaviour Support) Rules 2018 [F2018L00632] (NDIS rules).[53] The NDIS rules take a different approach to the instrument in regulating the use of restrictive practices in the disability sector, particularly in relation to the definition of restraint and in its interaction with state and territory laws.

2.36 The NDIS rules provide for five different types of restraint, which are then regulated differently. Under the NDIS rules, a 'regulated restrictive practice' involves any of the following:

- seclusion;
- chemical restraint;
- mechanical restraint, which is the use of a device to prevent, restrict, or subdue a person's movement for the primary purpose of influencing a person's behaviour but does not include the use of devices for therapeutic or non-behavioural purposes;

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51 See, for example, *Medical Treatment Planning and Decisions Act 2016* (Vic), sections 1, 4, 26, 50; *Guardianship Act 1987* (NSW), sections 6E-F; *Guardianship and Administration Act 2000* (Qld), sections 11, 65, 66; *Consent to Medical Treatment and Palliative Care Act 1995* (SA), Part 2A; *Guardianship and Administration Act 1995* (Tas), sections 25, 39; *Guardianship and Administration Act 1990* (WA), section 45, Part 9D.

52 See Australian Law Reform Commission, *Discussion Paper No 81: Equality, Capacity and Disability in Commonwealth Laws* (May 2014) p. 229.

53 In 2018, the committee considered the human rights compatibility of restrictive practices (including chemical and physical restraints) when examining the National Disability Insurance Scheme (Restrictive Practice and Behaviour Support) Rules 2018 [F2018L00632] (NDIS rules), see Parliamentary Joint Committee on Human Rights, *Report 13 of 2018* (4 December 2018) pp. 38-50; *Report 9 of 2018* (11 September 2018) pp. 7-19; *Report 7 of 2018* (14 August 2018) pp. 39-47.

- 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; and
- environmental restraint, which restricts a person's free access to all parts of their environment, including items or activities.[54]

2.37 The NDIS rules prescribe different conditions of registration of NDIS providers depending on the regulation of restrictive practices in a state or territory. Broadly, for those states and territories that prohibit the use of a restrictive practice, it is a condition of registration of the NDIS provider that the provider must not use the restrictive practice in relation to a person with a disability. However, where the practice is not prohibited by state or territory laws, it is regulated by an authorisation process.

2.38 The NDIS rules also prescribe the conditions of registration where a 'behaviour support plan' is used in relation to a regulated restrictive practice. The registration of specialist behaviour support providers is subject to the condition that the provider take all reasonable steps to reduce and eliminate the need for the use of regulated restrictive practices, and that any regulated restrictive practice must:

- be clearly identified in the behaviour support plan;
- be used only as a last resort in response to risk of harm to the person with disability or others, and after the provider has explored and applied evidence-based, person-centred and proactive strategies;
- be the least restrictive response possible in the circumstances to ensure the safety of the person and others;
- reduce the risk of harm to the person with disability or others;
- be in proportion to the potential negative consequence or risk of harm; and
- be used for the shortest possible time to ensure the safety of the person with disability or others.[55]

2.39 A person who is over the age of 65 years is not eligible to become a participant in the NDIS,[56] and aged care providers are not covered by the NDIS rules.

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54 NDIS rules, section 6.

55 NDIS rules, section 21(3).

56 *National Disability Insurance Scheme Act 2013*, section 22. Note: a person who is already an NDIS participant when they turn 65 has a choice of whether to remain the scheme or to switch to the Commonwealth aged care system.

Past inquiries and recommendations

2.40 The use of restraints in residential aged care facilities, and in the disability and health care sectors more broadly, has been considered in a number of recent reviews and inquiries, including:

- the Australian Law Reform Commission 2017 report into Elder Abuse;
- the NSW Law Reform Commission 2018 report into the *Guardianship Act 1987* (NSW); and
- the 2019 Report of the Senate Standing Committee on Community Affairs' inquiry into the 'Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised'.

2.41 Key recommendations from these reviews and inquiries include:

- any restraint should be the least restrictive and used only as a last resort, after alternative strategies have been considered, to prevent serious physical harm;[57]
- additional safeguards in relation to the use of restraints in residential aged care should be introduced, including independent oversight and mandatory reporting;[58] and
- there should be consistency between the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector and the regulation of the use of restraint in aged care sector.[59]

Royal Commission into Aged Care Quality and Safety

2.42 On 18 September 2018, the Minister for Senior Australians and Aged Care, the Hon. Ken Wyatt, asked the Department of Health to accelerate the process of regulating the use of medication in residential aged care.[60]

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57 Australian Law Reform Commission, *Report 131: Elder Abuse - A National Legal Response* (May 2017) p. 142 (Recommendation 4-10(a)).

58 Australian Law Reform Commission, *Report 131: Elder Abuse - A National Legal Response* (May 2017) p. 142 (Recommendation 4-11(a)); NSW Law Reform Commission, *Report 145: Review of the Guardianship Act 1987* (2018) p. 204.

59 Australian Law Reform Commission, *Report 131: Elder Abuse - A National Legal Response* (May 2017) p. 142 (Recommendation 4-11(c)); NSW Law Reform Commission, *Report 145: Review of the Guardianship Act 1987* (2018) p. 204; Senate Community Affairs References Committee, *Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised – Final Report* (2019), xiv (Recommendation 9).

2.43 The Royal Commission into Aged Care Quality and Safety was formally established on 8 October 2018, and, on 9 October, the Prime Minister announced the Terms of Reference, including the quality of care provided to older Australians, and the extent of substandard care; and the challenge of supporting the increasing number of Australians suffering dementia and addressing their care needs as they age.[61]

2.44 The Royal Commission is considering the same instrument as this inquiry, and has received submissions in relation to its potential impact on the quality of care provided to older Australians, including those with dementia. However, it does not share Parliament's role of exercising control over delegated legislation.

2.45 The Commissioners provided an interim report by 31 October 2019, and are required to provide a final report by 12 November 2020.[62]

60 ABC News, *Chemical and physical restraint: What happened to Terry could happen again under new rules* (27 June 2019) at: https://www.abc.net.au/news/2019-06-27/what-happened-to-terry-reeves-could-happen-again/11235804.

61 Prime Minister, Minister for Health, Minister for Senior Australians and Aged Care, *Media Release: Appointment of Royal Commissioners and Terms of Reference* (9 October 2019) at: https://consultations.health.gov.au/aged-care-policy-and-regulation/terms-of-reference/.

62 Royal Commission into Aged Care Quality and Safety, *Home page*, at: https://agedcare.royalcommission.gov.au/Pages/default.aspx.

Chapter 3

Key issues raised

3.1 The use of practices, devices or actions that interfere with people's ability to make decisions or restrict their free movement engages a number of Australia's obligations under international human rights law, particularly in circumstances where those restraints are used without the informed consent of the person restrained. While concerns have been raised that the instrument authorises the use of restraint in a manner that does not appropriately respect the right of aged care residents, the stated purpose of the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 (the instrument) is to limit the use of chemical and physical restraint by approved providers of residential care and short-term restorative care in a residential setting.[1] To do so the instrument sets out the circumstances in which physical and chemical restraint must not be used, except in specified circumstances.

Concerns raised by submitters and witnesses

3.2 Submitters to this inquiry, and witnesses at the public hearing, raised a range of concerns about the measures contained in the instrument.

3.3 The concerns raised can be loosely grouped into the following categories:

- the risk that the instrument might encourage the use of physical restraint without informed consent;
- the risk that the instrument might encourage excessive or inappropriate use of chemical restraint, including without consent;
- the lack of an explicit objective of eliminating the use of restraint;
- a lack of monitoring and oversight;
- the lack of clarity around the intersection of the instrument with existing regulatory frameworks;
- the inconsistency of the instrument with Australia's human rights obligations; and
- the disparity between these measures and the regulatory framework established under the National Disability Insurance Scheme.

1 Explanatory statement, p. 1.

Physical restraint and consent

3.4 Noting that the instrument would allow physical restraints to be used only where the aged care resident, or their 'representative', has consented to its use,[2] a number of witnesses raised particular concern about the vague definition of who is considered to be a 'representative' for the purposes of approving the use of physical restraint.[3] Ms Natalie Siegel-Brown, Queensland Public Guardian, described the consent measures as a 'tick and flick for the service provider', effectively authorising the voice of the person being subjected to a restraint to be ignored.[4] She argued that in the case of a physical restraint, an aged-care provider could go to a person without a real, close connection with the adult being impacted.[5] She posited that this could mean that a solicitor who holds a person's power of attorney in relation to financial decisions could be contacted to make a restraint decision about a person they have only met once, because 'the laws effectively give powers to guardians, regardless of what area they have been appointed as a decision-maker for, in a person's life'.[6] The Office of the Public Guardian of Queensland also noted that, as drafted, these principles would permit a person to nominate themselves as a representative, and be able to exercise the significant powers provided for where the aged care facility was satisfied that this person had a connection with the patient and was concerned for their safety, health and wellbeing.[7]

3.5 Professor Rosalind Croucher, President of the Australian Human Rights Commission, similarly raised concerns about the apparent breadth of the 'representative' category, and the need for careful definition of the term to avoid confusion about the nature of the authority that a person acting under such powers possesses.[8] Ms Elaine Pearson of Human Rights Watch, likewise, argued that the vague definition would enable an aged-care provider to simply approach a relative who would be most amenable to supporting a proposed restraint on a particular individual in order to obtain consent.[9]

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2 Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019, subsection 15F(1).

3 See, for example, Elderlaw, *Submission 14*, p. 30.

4 Ms Natalie Siegel-Brown, Queensland Public Guardian, *Hansard*, 20 August 2019, p. 4.

5 Ms Natalie Siegel-Brown, Queensland Public Guardian, *Hansard*, 20 August 2019, p. 4.

6 Ms Natalie Siegel-Brown, Queensland Public Guardian, *Hansard*, 20 August 2019, p. 4. See also Relationships Australia, *Submission 17*, p. 15.

7 Office of the Public Guardian (Queensland), *Submission 1*, p. 6.

8 Professor Rosalind Croucher, President, Australian Human Rights Commission, *Hansard*, 20 August 2019, p. 59.

9 Ms Elaine Pearson, Australia Director, Human Rights Watch, *Hansard*, 20 August 2019, p. 14.

3.6 The Office of the Public Guardian of Queensland argued that this law, by using the definition of representative established in the Quality of Care Principles 2014, has the effect of significantly interfering with State Guardianship legislation and compromising the powers of the Public Guardian of Queensland, and of private guardians and people appointed under Enduring Powers of Attorney.[10] The Office stated that, as drafted, these principles purport to give powers to a guardian to decide whether a restraint should be used regardless of the domain in which they have been appointed to act as a guardian in a person's life.[11]

3.7 Ms Siegel-Brown, Queensland Public Guardian, also raised concerns about the practical implications where no consent has been provided. She alleged she has experienced that, when her office refuses to make a restraint decision about a person under its care, aged-care providers will refuse to admit those clients to the facility, and the clients will remain longer in hospital or be placed in other precarious situations.[12] Ms Siegel-Brown warned that where a representative does not consent to the use of a restraint, she feared that resort will consequently be had to chemical restraints, and alleged there will be a surge in their use.[13] The National Association of Community Legal Centres similarly argued that, as currently drafted, section 15F regulating the use of physical restraint could enable providers to simply rely on the 'emergency' discretion to use physical restraints, noting the apparent lack of a process for institutional monitoring of this emergency discretion.[14]

3.8 Professor Susan Kurrle, member of the Australian and New Zealand Society for Geriatric Medicine, posited that it must be made more difficult to prescribe the use of physical restraints, and suggested that the Dementia Behaviour Management Advisory Service should be required to see residents before physical restraints can be prescribed.[15] In this regard, the Australian College of Nurse Practitioners submitted that '[t]he omission of reference to established behaviour plans, written and agreed to with the individual or consenting person/s responsible, places this instrument well behind comparable sectors.'[16]

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10 Office of the Public Guardian (Queensland), *Submission 1*, p. 5.

11 Office of the Public Guardian (Queensland), *Submission 1*, p. 6.

12 Ms Natalie Siegel-Brown, Queensland Public Guardian, *Hansard*, 20 August 2019, p. 4.

13 Ms Natalie Siegel-Brown, Queensland Public Guardian, *Hansard*, 20 August 2019, pp. 4 and 6. See also Office of the Public Guardian (Queensland), *Submission 1*, p. 9.

14 National Association of Community Legal Centres, *Submission 4*, p. 4.

15 Professor Susan Kurrle, Member of the Australian and New Zealand Society for Geriatric Medicine, *Hansard*, 20 August 2019, p. 31.

16 Australian College of Nurse Practitioners, *Submission 9*, p. 3.

Regulation of chemical restraint

Chemical restraint and consent

3.9 Noting that the instrument provides that chemical restraint can be used where a medical or nurse practitioner has prescribed the relevant medication, and where the resident's representative is 'informed' before the restraint is used 'if it is practicable to do so',[17] several witnesses and submitters raised significant concerns about the absence of a requirement for informed consent to be obtained (as is required by the instrument in the case of physical restraints).[18]

3.10 Ms Siegel-Brown noted that guardianship principles require a guardian to presume that a person has the capacity to make their own decisions, and posited that it is not appropriate to presume that a decision about chemical restraint should be a doctor's decision.[19] Dr Juanita Breen of the Wicking Dementia Research and Education Centre noted:

> The fact that consent, let alone informed consent, is not required in the new principles sends a clear message that restraining someone using medication is something that should be solely decided by the prescriber, usually a doctor. The principles show a stunning disregard for the rights of older vulnerable residents and the relatives, friends or proxy that legally represent them if they lack the capacity to make decisions for themselves.[20]

3.11 Other witnesses also raised concerns about families not being advised or consulted prior to the administration of chemical restraints. Ms Elaine Pearson of Human Rights Watch stated that her organisation had been advised of numerous instances where medication was prescribed to a person without any consent from that person, and that family members, who held powers of attorney to act on behalf of a resident, were only being informed when they received the bills for the medications.[21] Dr Juanita Breen likewise noted that she had herself conducted research and interviewed individuals who had only discovered the use of a medication when it appeared on their parents' pharmacy bill, indicating that consent

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17 Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019, subsection 15G(1).

18 See, for example, National Association of Community Legal Centres*, Submission 4*, p. 5.

19 Ms Natalie Siegel-Brown, Queensland Public Guardian, *Hansard*, 20 August 2019, p. 7.

20 Dr Juanita Breen, Senior Lecturer, Wicking Dementia Research and Education Centre, University of Tasmania, *Submission 10*, p. 3.

21 Ms Elaine Pearson, Australia Director, Human Rights Watch, *Hansard*, 20 August 2019, p. 11. See also Human Rights Watch, *Fading Away: How Aged Care Facilities in Australia Chemically Restrain Older People with Dementia* (2019) p. 3.

had not been sought.[22] Similar findings were also documented in the Interim Report of the Royal Commission into Aged Care Quality and Safety.[23]

Inappropriate use of chemical restraints

3.12 Several witnesses raised concerns about the risk that the instrument might result in chemical restraints being used too extensively, and made observations about existing issues of over-prescription of psychotropics among aged care patients. Dr Breen posited that the measures in this instrument do little to address the high rates of inappropriate psychotropic prescriptions in aged-care homes, and that by making chemical restraint the 'easier or preferable restraint' it could in fact increase their use.[24]

3.13 Dr Colleen Pearce, the Victorian Public Advocate, cautioned that although pharmaceutical aids may be provided to a person in order to treat a particular illness, they may continue to be provided for longer than necessary, and in fact be provided to address behavioural issues.[25] She explained that in Victoria, senior practitioners who are experts in the field (neither nurses nor medical practitioners) provide guidance and strategies to help deal with behavioural issues.[26] Ms Natalie Siegel-Brown, the Queensland Public Guardian, echoed these concerns, explaining that she also had experience of drugs such as diazepam being prescribed initially to treat a behavioural problem, but then become convenient to continue administering, and so 'suddenly we'll see a diagnosis come into being so that there's effectively an excuse to use that chemical restraint'.[27] Ms Mary Burgess, the Queensland Public Advocate, similarly highlighted evidence of the over-prescription of some drugs in aged-care facilities, and stated that 90 per cent of the instances of benzodiazepines and antipsychotics being prescribed in aged-care facilities could not be justified, even in terms of managing behaviour.[28]

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22 Dr Juanita Breen, Senior Lecturer, Wicking Dementia Research and Education Centre, University of Tasmania, *Hansard*, 20 August 2019, p. 18. See also similar anecdotal comments from Dementia Australia, *Submission 16*, p. 3, and Aged and Disability Advocacy Australia, *Submission 2*, p. 4.

23 Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect, Volume 1* (31 October 2019), pp. 208-209.

24 Dr Juanita Breen, Senior Lecturer, Wicking Dementia Research and Education Centre, University of Tasmania, *Hansard*, 20 August 2019, p. 17.

25 Dr Colleen Pearce, Public Advocate, Office of the Public Advocate (Victoria), *Hansard*, 20 August 2019, p. 5.

26 Dr Colleen Pearce, Public Advocate, Office of the Public Advocate (Victoria), *Hansard*, 20 August 2019, p. 5.

27 Ms Natalie Siegel-Brown, Queensland Public Guardian, *Hansard*, 20 August 2019, p. 5.

28 Ms Mary Burgess, Public Advocate, Office of the Public Advocate (Queensland), *Hansard*, 20 August 2019, p. 6.

3.14 Dr Robert Herkes and Professor Anne Duggan from the Australian Commission on Safety and Quality in Health Care noted that their research had 'found a very high rate of use of anti-psychotics' in those over 65, and that this had not gone down despite their recommendations to address this over-use.[29]

3.15 The Office of the Public Guardian of Queensland described the foreseeability of an increase in staff opting for the use of chemical restraint which would appear to be less work, describing this situation as 'extraordinarily dangerous'.[30] The Public Guardian, Ms Siegel-Brown, argued that aged care service providers and their associated medical practitioners have a conflict of interest when it comes to managing their own internal workloads, and that this can influence decisions about chemical restraint.[31]

3.16 Aged and Disability Advocacy Australia raised similar concerns, arguing that the relationship between the prescribing medical professional and aged care service provider is likely to be closer than that between the doctor and the patient themselves, leading to a divided loyalty.[32] Dr Harry Nespolon, President of the Royal Australian College of General Practitioners, argued that it would be preferable for patients to have a choice of external doctor, rather than a doctor who is engaged in an employer-employee or principal-contractor relationship with the aged-care facility.[33] Mr Geoff Rowe, Chief Executive Officer of Aged and Disability Advocacy Australia, also argued that stronger legislation is needed to protect the elderly, citing anecdotal evidence of poor conduct by doctors attending aged care facilities, including failing to see any patients, or ignoring care plans which had been developed to help manage people's behaviours.[34]

3.17 Submitters also raised concerns that the instrument did not appear to prevent chemical restraints being inappropriately prescribed to treat anti-social or disruptive behaviours. Dr Breen stated that many aged care residents are prescribed psychotropics (including antidepressants, anxiolytic-hypnotics, and antipsychotics) for things like wandering, resisting care, calling out, and to try to get them to sleep.[35]

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29 Dr Robert Herkes and Professor Anne Duggan, Acting Chief Executive Officer and Acting Chief Medical Officer, Australian Commission on Safety and Quality in Health Care, *Hansard*, 20 August 2019, p. 22.

30 Office of the Public Guardian (Queensland), *Submission 1*, p. 8.

31 Ms Natalie Siegel-Brown, Queensland Public Guardian, *Hansard*, 20 August 2019, p. 6.

32 Aged and Disability Advocacy Australia, *Submission 2*, pp. 1-2.

33 Dr Harry Nespolon, President, The Royal Australian College of General Practitioners, *Hansard*, 20 August 2019, p. 33.

34 Mr Geoff Rowe, Chief Executive Officer, Aged and Disability Advocacy Australia, *Hansard*, 20 August 2019, p. 52.

35 Dr Juanita Breen, Senior Lecturer, Wicking Dementia Research and Education Centre, University of Tasmania, *Hansard*, 20 August 2019, p. 16.

Aged and Disability Advocacy Australia argued that such prescriptions conflict with professional guidance set out by the Royal Australian and New Zealand College of Psychiatrists, which states that people with anti-social behaviours are not indicated for the use of anti-psychotics.[36] Dr Breen also argued that in not addressing these issues and by allowing for prescriptions to be provided by doctors who have not personally examined their patients, the instrument is inconsistent with professional recommendations that a detailed assessment be conducted *before* the use of psychotropic medications:

> The doctor doesn't even have to come in and physically examine the resident to exclude perhaps contributing factors such as infection and pain. There doesn't have to be a documenting or a trial of all available non-drug options or the use of the least restrictive option. There is no stipulation that you need to use the lowest effective dose. There's no monitoring for effectiveness or for side effects. There's no setting of a maximum duration of use, let alone planning for dose reduction or cessation, as all guidelines really stress. These general recommendations are included in all national and international guidelines for psychotropic drug use. It's perplexing that the new principles go against a 2012 federal publication called Decision-making tool: supporting a restraint free environment in community aged care. The thing about that is that it was endorsed by the present government.[37]

3.18 Dr Breen argued that all restraints, be they physical or chemical, should be legislated against and treated equally:

> Whether it's chemical, whether it's tying someone up to a chair, whether it's restricting them to a room, I think you should have a consistent approach. You can't say that, with all other forms of restraint, apart from chemical, you need informed consent but it's okay with chemical. There are quite strict stipulations for physical restraint but not for chemical restraint, and I just think we need to recognise that it's not more acceptable. Restraint is restraint, and it should be legislated against and treated equally.[38]

3.19 The Queensland Public Guardian, Ms Siegel-Brown, stated that, in her experience, there are instances where a doctor, having only heard another medical practitioner's side of a story, in the case of a non-verbal client, may not elicit the kind of information that a senior practitioner or other advocate may:

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36 Aged and Disability Advocacy Australia, *Submission 2*, p. 3.

37 Dr Juanita Breen, Senior Lecturer, Wicking Dementia Research and Education Centre, University of Tasmania, *Hansard*, 20 August 2019, p. 17.

38 Dr Juanita Breen, Senior Lecturer, Wicking Dementia Research and Education Centre, University of Tasmania, *Hansard*, 20 August 2019, p. 20.

> I can think of an instance where a person had been provided anti-libidinal medication because it was believed he was trying to grab people's breasts. It was a person who was non-verbal. When we asked further questions, it became clear that this gentleman…had no intention of trying to grab somebody's breasts; he was trying to indicate that he wanted food, that he was hungry….So we were able to remove the anti-libidinal drugs, which had horrific side-effects such as weakening bone density and increasing the chance of heart failure and kidney failure. There are numerous instances like this, where, in our senior practitioner role and in our advocacy role, we're able to reverse and eliminate the use of chemical restraints as a result of getting people to understand the client better.[39]

3.20 Several witnesses also noted concerns about health risks associated with the use of chemical restraints. Ms Elaine Pearson, Australia Director of Human Rights Watch argued that where chemical restraints have been employed, these can reduce a person's ability to communicate and seek help for health issues.[40] A subsequent Human Rights Watch report also documents the links between the use of chemical restraint and the risk of death, as well as 'severe nervous system problems' and a range of other serious health issues, including 'high blood sugar and diabetes; and low blood pressure, which causes dizziness and fainting', as well as stroke, blood clots, visual disturbances and metabolic effects.[41] Dr Breen likewise noted that psychotropics are associated with falls and pneumonia, and antipsychotics are associated with death.[42] She stated that they also cause 'confusion and movement problems and impair the social engagement of residents'.[43] Dr Kaele Stokes of Dementia Australia argued that only a very small proportion of patients for whom psychotropics are prescribed will be positively impacted, and all patients face the increased risk factors associated with the prescription of a sedative, including falls and stroke.[44] When asked to elaborate on the range of health risks associated with the use of antipsychotic drugs for older people with dementia, Professor Ibrahim

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39 Ms Natalie Siegel-Brown, Queensland Public Guardian, *Hansard*, 20 August 2019, p. 8.

40 Ms Elaine Pearson, Australia Director, Human Rights Watch, *Hansard*, 20 August 2019, p. 12.

41 Human Rights Watch, *Fading Away: How Aged Care Facilities in Australia Chemically Restrain Older People with Dementia* (2019) pp. 17-19.

42 Dr Juanita Breen, Senior Lecturer, Wicking Dementia Research and Education Centre, University of Tasmania, *Hansard*, 20 August 2019, p. 16.

43 Dr Juanita Breen, Senior Lecturer, Wicking Dementia Research and Education Centre, University of Tasmania, *Hansard*, 20 August 2019, p. 16.

44 Dr Kaele Stokes, Executive Director, Advocacy and Research, Dementia Australia, *Hansard*, 20 August 2019, p. 56.

noted, 'I don't know that we need more complications than death and stroke; surely it is enough that it does that.'[45]

3.21 Similar issues were also noted in the Interim Report of the Royal Commission into Aged Care Quality and Safety, which documents the both anecdotal and empirical evidence of the over-prescription and misuse of chemical restraints, and the serious impact of these restrictive practices on physical and psychological health.[46]

3.22 A number of medical witnesses also noted the difficulty in distinguishing between the use of prescription medication for therapeutic purposes compared to restraint purposes. Dr Roderick McKay, Fellow of the Royal Australian and New Zealand College of Psychiatrists, submitted that, in his experience, general practitioners are increasingly 'very concerned about either commencing or continuing psychotropic medication for any purpose' due to the difficulty of defining what a 'chemical restraint' is.[47] Professor Ibrahim commented that there is 'strong evidence that [antipsychotic drugs] are inappropriately prescribed'.[48]

3.23 Dr Nespolon, President of the Royal Australian College of General Practitioners, posited that it is difficult to imagine a patient who is getting medication *solely* for the purposes of chemical restraint.[49] Ms Hazel Bucher, Board Member and National Secretary of the Australian College of Nurse Practitioners, echoed the concerns about defining chemical restraint.[50] She argued that in practice, individuals may have been prescribed psychotropic or other medications prior to moving into a nursing home, and that on their admission to the home the prescription becomes an issue of restraint.[51] She also argued that doctors bear some of the blame, positing that, historically, a lack of follow-up on those prescriptions by general practitioners who operate externally has been problematic, and so the Australian College of Nurse

45 Professor Joseph Ibrahim, Head, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University, *Hansard,* 20 August 2019, p. 16.

46 Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect, Volume 1* (31 October 2019), pp. 198-200.

47 Dr Roderick McKay, Fellow of the Royal Australian and New Zealand College of Psychiatrists, *Hansard*, 20 August 2019, pp. 30 and 36.

48 Professor Joseph Ibrahim, Head, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University, *Hansard,* 20 August 2019, p. 16.

49 Dr Harry Nespolon, President, The Royal Australian College of General Practitioners, *Hansard*, 20 August 2019, p. 37.

50 Ms Hazel Bucher, Board Member and National Secretary of the Australian College of Nurse Practitioners, *Hansard*, 20 August 2019, p. 31.

51 Ms Hazel Bucher, Board Member and National Secretary of the Australian College of Nurse Practitioners, *Hansard*, 20 August 2019, p. 31.

Practitioners is considering new models where nurses can de-prescribe such medications.[52]

3.24 Dr Nespolon further argued that doctors are generally trying to prescribe the least amount of drugs, especially for older patients, and so adding too much regulation is not a good thing.[53] Professor Susan Kurrle, Member of the Australian and New Zealand Society for Geriatric Medicine, suggested that a requirement that only specialists be able to prescribe psychotropic medication would reduce the pressure on general practice doctors, who could no longer be approached by family members or residential-care staff to make such prescriptions.[54]

Reducing and eliminating restrictive practices

3.25 Submitters raised concerns that, as currently drafted, the instrument does not require that approved aged-care providers take all reasonable steps to reduce and eliminate the need for the use of restrictive practices. Ms Elaine Pearson of Human Rights Watch argued that the instrument does not prohibit 'the use of physical or chemical restraints for control, punishment or retaliation or as a measure of convenience for nursing facility staff.'[55]

3.26 Several witnesses considered that this measure will not, in fact, reduce the use of restraints in practice. Mr Craig Gear, Chief Executive Officer of the Older Persons Advocacy Network, argued that, as drafted, this instrument would permit chemical restraint to be used indefinitely and does not require authorisation for a restrictive practice to be time-limited.[56] He also noted that the instrument does not compel the use of alternative practices prior to the use of restrictive practices, or provide for prerequisites such as skilled behaviour assessments and documentation.[57] Dr Kaele Stokes, Executive Director of Advocacy and Research with Dementia Australia, similarly argued that the measures do not combat the overuse of psychotropics as a form of chemical restraint, nor do they combat confusion about

52 Ms Hazel Bucher, Board Member and National Secretary of the Australian College of Nurse Practitioners, *Hansard*, 20 August 2019, p. 32.

53 Dr Harry Nespolon, President, The Royal Australian College of General Practitioners, *Hansard*, 20 August 2019, p. 35.

54 Professor Susan Kurrle, Member, Australian and New Zealand Society for Geriatric Medicine, *Hansard*, 20 August 2019, p. 31.

55 Ms Elaine Pearson, Australia Director, Human Rights Watch, *Hansard*, 20 August 2019, p. 10.

56 Mr Craig Gear, Chief Executive Officer, Older Persons Advocacy Network, *Hansard*, 20 August 2019, p. 55.

57 Mr Craig Gear, Chief Executive Officer, Older Persons Advocacy Network, *Hansard*, 20 August 2019, p. 55.

the roles of various healthcare workers in determining whether a form of restraint is in fact a last resort.[58]

3.27 Ms Natalie Siegel-Brown, the Queensland Public Guardian, similarly raised concern about a lack of safeguards, noting that there is no requirement under the new principles to consider or address how an aged care facility will reduce or eliminate restraint, or how they will develop positive behaviour support plans which are the industry standard in the disability sector.[59] Ms Siegel Brown posited that the consent requirements under these measures are a key issue, arguing that aged-care facilities are being explicitly permitted to ask a person 'who's not qualified–and may not know a person very well–to make that decision in an arena where you would have hoped that they would have given that decision-making power to the person themselves'.[60] She argued that the regulation of restrictive practices requires:

> a regime where consent is given by a body that is informed and that has proper jurisdiction to give consent, and also one that prioritises the ability of the person to consent to restrictive practices that are going to be used against themselves. If you look at the way it's done everywhere else, there's a presumption of what we call capacity. There's a presumption of decision-making by the person.[61]

3.28 Professor Susan Kurrle, Member of the Australian and New Zealand Society for Geriatric Medicine, and Professor Joseph Ibrahim of the Health Law and Ageing Research Unit at Monash University, both cautioned that the instrument contains significant gaps, which would enable people to circumvent restrictions on the application of restraints.[62] Mr Geoff Rowe, Chief Executive Officer of Aged and Disability Advocacy Australia, similarly argued that this instrument will legitimise the poor behaviour which is already occurring in aged-care facilities.[63]

3.29 Human Rights Watch submitted that Australia should be working to end the use of all forms of restraint in aged care, instead of regulating these practices.[64] Ms Elaine Pearson, Australia Director of Human Rights Watch, highlighted the

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58 Dr Kaele Stokes, Executive Director, Advocacy and Research, Dementia Australia, *Hansard*, 20 August 2019, p. 56.

59 Ms Natalie Siegel-Brown, Queensland Public Guardian, *Hansard*, 20 August 2019, p. 4.

60 Ms Natalie Siegel-Brown, Queensland Public Guardian, *Hansard*, 20 August 2019, p. 8.

61 Ms Natalie Siegel-Brown, Queensland Public Guardian, *Hansard*, 20 August 2019, p. 8.

62 Professor Susan Kurrle, Member, Australian and New Zealand Society for Geriatric Medicine, *Hansard*, 20 August 2019, p. 35; Professor Joseph Ibrahim, Head, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University, *Hansard,* 20 August 2019, p. 21.

63 Mr Geoff Rowe, Chief Executive Officer, Aged and Disability Advocacy Australia, *Hansard*, 20 August 2019, p. 50.

64 Human Rights Watch, *Submission 8*, p. 3.

importance of establishing 'supportive decision-making,' which involves trying to get free and informed consent from a person, including by attempting to communicate with them more than once and using a range of methods.[65] She argued that alternatives to chemical restraints are available; including simple alternative techniques to de-agitate people which have been demonstrated in facilities that do not use chemical restraints.[66]

3.30 As Dr Juanita Breen noted in her submission, the Department of Health's *Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care 2012* states that the use of restraint should always be the last resort and viewed as a temporary solution to any behaviour causing concerns. However, these guidelines are not legislative requirements, and these requirements are not set out in the instrument.[67]

3.31 Professor Joseph Ibrahim, of the Health Law and Ageing Research Unit at Monash University, argued that any person who requires restraint should have a formal structured multidisciplinary assessment because physically or chemically restraining them will not actually solve the underlying problem.[68] He further argued that training of aged care staff is one factor in reducing the application of restraints. He, and other witnesses,[69] posited that aged-care staff require education and training to develop the skills and knowledge to 'assess why a person has responsive behaviours or unmet needs to address that', but argued that this regulation does not achieve that.[70]

3.32 Mr Geoff Rowe, Chief Executive Officer of Aged and Disability Advocacy Australia, echoed the argument that training staff provides them with a range of skills to manage challenging behaviour, but also that consistency in staffing plays a key role in maintaining relationships between staff and patients.[71] Several witnesses similarly posited that understaffing of aged-care facilities is one of the key underlying contributors to the use of restraints. Ms Melissa Coad, Executive Projects Coordinator of United Voice, cited anecdotal evidence from union members that

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65 Ms Elaine Pearson, Australia Director, Human Rights Watch, *Hansard*, 20 August 2019, p. 13.

66 Ms Elaine Pearson, Australia Director, Human Rights Watch, *Hansard*, 20 August 2019, p. 12.

67 Dr Juanita Breen, *Submission 10*, p. 3.

68 Professor Joseph Ibrahim, Head, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University, *Hansard,* 20 August 2019, pp. 19 and 21.

69 Mr Geoff Rowe, Chief Executive Officer, Aged and Disability Advocacy Australia, *Hansard*, 20 August 2019, p. 52; Dr Kaele Stokes, Executive Director, Advocacy and Research, Dementia Australia, *Hansard*, 20 August 2019, p. 56.

70 Professor Joseph Ibrahim, Head, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University, *Hansard,* 20 August 2019, pp. 18-19.

71 Mr Geoff Rowe, Chief Executive Officer, Aged and Disability Advocacy Australia, *Hansard*, 20 August 2019, p. 52. See also Relationships Australia, *Submission 17*, p. 18.

understaffing is leading workers to rush residents, who then become aggressive or agitated as a result.[72] Ms Julia Reeves, Federal Professional officer of the Australian Nursing and Midwifery Federation, argued that 'if the root causes for undesired behaviours are determined and corrected, the use of restraints can be significantly reduced and alternatives can be implemented', but to do this there needs to be 'the right staffing numbers and the skill mix to enable effective assessment and monitoring to provide person-centred care.'[73]

3.33 The Interim Report of the Royal Commission into Aged Care Quality and Safety documents similar concerns, and notes that '[e]xpert witnesses at our Sydney Hearing did not express confidence that the Principles [the instrument] would reduce the behaviour of prescribing medical practitioners.'[74]

3.34 In this context, Leading Aged Services Australia submitted that it 'believes it is the responsibility of aged care providers and their care staff…to minimise the use of restraint in residential aged care settings and aspire to a restraint free environment' and that the principle that restraint should be a last resort is widely accepted across the sector.[75] Leading Aged Services Australia also submitted that '[a]n educational approach to behavioural change by care givers to be the best first line response when seeking to change practice.'[76]

Oversight and review of decisions to use restraints

3.35 A number of submitters and witnesses raised concerns about the lack of monitoring and oversight associated with the use of restraints.[77] Older Persons Advocacy Network raised particular concern about the absence of a higher form of authorisation than that prescribed for other regular and non-restrictive medications.[78] Aged and Disability Advocacy Australia noted with concern the absence of a mechanism 'to change care arrangements in order to reduce or

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72 Ms Melissa Coad, Executive Projects Coordinator of United Voice, *Hansard*, 20 August 2019, p. 40.

73 Ms Julia Reeves, Federal Professional officer of the Australian Nursing and Midwifery Federation, *Hansard*, 20 August 2019, pp. 39-40.

74 Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect, Volume 1* (31 October 2019), p. 209.

75 Leading Aged Services Australia, *Submission 6*, p. 3.

76 Leading Aged Services Australia, *Submission 6*, p. 3.

77 Ms Natalie Siegel-Brown, Queensland Public Guardian, *Hansard*, 20 August 2019, p. 4; Advocacy for Inclusion, *Submission 12*, p. 2; Older Persons Advocacy Network, *Submission 11*, p. 4; National Association of Community Legal Centres, *Submission 4*, p. 5; Dr Juanita Breen, *Submission 10*, p. 4.

78 Older Persons Advocacy Network, *Submission 11*, p. 3. See also, Office of the Public Guardian (Queensland), *Submission 1*, p. 11 regarding the suggestion for a higher regulatory standard for restrictive practices.

extinguish the use of restraints.'[79] Professor Rosalind Croucher, President of the Australian Human Rights Commission, advocated that independent oversight of the use of restrictive practices in residential aged care is necessary, and pointed to the Victorian model as a good example.[80] Human Rights Watch similarly proposed that any new law in this area should ensure independent monitoring.[81]

3.36 The Queensland Public Guardian, Ms Siegel-Brown, questioned how these principles will have any real impact if they are not monitored by 'an empowered legislated community visitor's scheme.'[82] As her office noted in its submission, Queensland has a program to provide for independent oversight of state government funded mental health services and disability facilities, and recommended that something similar be adopted at the Commonwealth level for residential aged care facilities with legislated powers to monitor, inquire, complain and advocate.[83] Ms Siegel-Brown explained that one of the chief things that community visitors look for in disability and mental health services is whether restrictive practices are being used in the manner for which they were authorised.[84] She stated that in some jurisdictions they have legislated powers to raise complaints and advocate for consumers, and that in the federal disability regime they can raise issues with the NDIS Quality and Safeguards Commission, and that such complaints can result in service providers losing their registration.[85]

3.37 A number of suggestions for improved independent oversight were made. The Office of Public Guardian Queensland recommended that an investigative body be empowered to apply disciplinary measures.[86] Professor Croucher, of the Australian Human Rights Commission, noted that, in the context of the prohibition against torture and other cruel inhuman or degrading treatment, aged-care facilities are considered to be subject to the operation of the Optional Protocol to the Convention Against Torture.[87] She explained that the practical effect of this would be

79 Aged and Disability Advocacy Australia, *Submission 2*, p. 1.

80 Professor Rosalind Croucher, President, Australian Human Rights Commission, *Hansard*, 20 August 2019, p. 60.

81 Human Rights Watch, *Submission 8*, p. 3.

82 Ms Natalie Siegel-Brown, Queensland Public Guardian, *Hansard*, 20 August 2019, p. 4.

83 Office of Public Guardian (Queensland), *Submission 1*, p. 10.

84 Ms Natalie Siegel-Brown, Queensland Public Guardian, *Hansard*, 20 August 2019, p. 8.

85 Ms Natalie Siegel-Brown, Queensland Public Guardian, *Hansard*, 20 August 2019, p. 9.

86 Office of Public Guardian (Queensland), *Submission 1*, p. 10.

87 Professor Rosalind Croucher, President, Australian Human Rights Commission, *Hansard*, 20 August 2019, p. 62.

to enable inspections of aged-care residential facilities as part of a national preventative mechanism.[88]

3.38 In this context, representatives of the Aged Care Quality and Safety Commission gave evidence around its role as a regulator, including its quality assessment, monitoring, complaints, consumer engagement, education and outreach functions.[89] Ms Christina Mary Bolger, Executive Director of Regulatory Policy and Performance from the Commission, emphasised that '[b]ecause of the high potential for harm arising from the use of restraints, the Commission is looking very closely at this in our regulatory practice.'[90] She highlighted a number steps that the Commission has taken 'since the introduction of the new regulations…including a self-assessment tool' and the fact that the Commission has 'sharpened our focus in our reaccreditation audits and our compliance monitoring on the use of chemical and physical restraint.'[91] She further emphasised the Commission's commitment to this issue, stating:

> We're seeing some evidence of early increased awareness in the sector as a result of these activities. We know there is a way to go with this. We'll continue to monitor that closely and to look for further evidence that we're seeing the behaviour change that's necessary to improve outcomes for consumers and ensure that restraints are used only as a last resort and not until alternative strategies have been considered.[92]

3.39 However, the National Association of Community Legal Centres submitted that the Aged Care Act, the instrument and the Aged Care Quality and Safety Commission's complaints resolution processes are founded on a consumer protection model, which does not provide sufficient protection for older Australians from serious human rights breaches, noting the particular vulnerability of older people. National Association of Community Legal Centres noted that individual complaints are dealt with under a dispute resolution model, which does not provide individual rights with associated remedies and redress. It submitted that the gravity of matters such as those arising from the use of restraints is ill-suited to dispute

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88 Professor Rosalind Croucher, President, Australian Human Rights Commission, *Hansard*, 20 August 2019, p. 62.

89 Ms Christina Mary Bolger, Executive Director of Regulatory Policy and Performance, Aged Care Quality and Safety Commission, *Hansard*, 20 August 2019, p. 23.

90 Ms Christina Mary Bolger, Executive Director of Regulatory Policy and Performance, Aged Care Quality and Safety Commission, *Hansard*, 20 August 2019, pp. 22-23.

91 Ms Christina Mary Bolger, Executive Director of Regulatory Policy and Performance, Aged Care Quality and Safety Commission, *Hansard*, 20 August 2019, p. 23.

92 Ms Christina Mary Bolger, Executive Director of Regulatory Policy and Performance, Aged Care Quality and Safety Commission, *Hansard*, 20 August 2019, p. 23.

resolution and that the outcomes of the aged care complaints system are not the effective remedy required under international law.[93]

Intersection with existing regulatory frameworks

3.40 Witnesses raised questions around whether the relationship between the instrument and the broader regulatory framework was sufficiently clear. Dr Roderick McKay, Fellow of the Royal Australian and New Zealand College of Psychiatrists, questioned the practical operation of this instrument in its broader legislative context, arguing that there appears to be a risk that someone may read this and overlook the implications of state legislation in the broader legislative context.[94] Dr Colleen Pearce also argued that, in her experience, it appears that the consent process set out under Victorian law is not being adhered to:

> The Medical Treatment Planning and Decisions Act commenced on 12 March 2018. Since that time my office has received less than 20 applications for me to consent to, or refuse, pharmaceutical treatment for residents in aged care. Given the number of people in residential aged care facilities, the percentage who have impaired decision-making capacity to consent to treatment, the percentage of those who do not have a medical treatment decision-maker, I think it unlikely that the consent process…is being adhered to in residential aged care facilities in Victoria.
>
> If the use of restraint is medical treatment requiring consent under Victorian statute law, I do not see how the Rules as currently conceived, and written, will address what I suspect is an extraordinary degree of non-compliance.[95]

3.41 However, Dr Melanie Wroth, Chief Clinical Adviser at the Aged Care Quality and Safety Commission, advised that pursuant to standard eight in the clinical governance arrangements, there is a requirement that chemical restraint only be used for the minimum time necessary, and that standard five dealing with 'comprehensive care' requires the use of best practice, legislative compliance, and being 'clinically sensible'.[96] She further stated that the Commission was making it 'explicitly clear that not having a representative does not mean that that person does

93 National Association of Community Legal Centres, *Submission 4*, pp. 2-3.

94 Dr Roderick McKay, Fellow of the Royal Australian and New Zealand College of Psychiatrists, *Hansard*, 20 August 2019, p. 36.

95 Document provided as additional information on 17 September 2019 by the Public Advocate (Victoria) - Response to Department of Health response to questions from the committee, pp. 2-3.

96 Dr Melanie Wroth, Chief Clinical Adviser, Aged Care Quality and Safety Commission, *Hansard*, 20 August 2019, p. 29.

not need to have someone providing informed consent' for both chemical and physical restraints.[97]

3.42 Dr Wroth also advised:

> Consent for medication is governed by state and territory laws. In the principles, it does say that state and territory laws continue to apply. Unfortunately, the state and territory laws differ slightly between jurisdictions…We are taking the view that, to give any psychotropic medication, informed consent is still required as per all state and territory laws.[98]

3.43 Dr Robert Herkes from the Australian Commission on Safety and Quality in Health Care also advised:

> Within the healthcare system we would expect that clinicians would not administer anything—any medication or any restraint—without excluding causes for the problem that they're wanting to give restraint for, such as constipation, dehydration, malnutrition, fevers, urinary tract infections or what have you. Whether it's physical or chemical restraint, within the healthcare system the clinician has to be sure that there is appropriate justification for using a physical restraint or a medical restraint. To our mind, that should include informed consent.[99]

Human rights concerns

3.44 In light of the concerns raised, numerous submitters and witnesses argued that the measures contained in the instrument are generally inconsistent with Australia's human rights obligations.[100] Some submitters and witnesses to this inquiry raised specific concerns as to the manner in which the measures engage and limit the following human rights:

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97 Dr Melanie Wroth, Chief Clinical Adviser, Aged Care Quality and Safety Commission, *Hansard*, 20 August 2019, p. 26.

98 Dr Melanie Wroth, Chief Clinical Adviser, Aged Care Quality and Safety Commission, *Hansard*, 20 August 2019, p. 27.

99 Dr Robert Herkes, Acting Chief Executive Officer, Australian Commission on Safety and Quality in Health Care, *Hansard*, 20 August 2019, p. 27.

100 See, Dr Colleen Pearce, Public Advocate, Office of the Public Advocate (Victoria), *Hansard*, 20 August 2019, p. 1; Ms Natalie Siegel-Brown, Queensland Public Guardian, *Hansard*, 20 August 2019, p. 9; Mr Geoff Rowe, Chief Executive Officer, Aged and Disability Advocacy Australia, *Hansard*, 20 August 2019, p. 49; Ms Elaine Pearson, Australia Director, Human Rights Watch, *Hansard*, 20 August 2019, p. 10; Mr Bill Mitchell, Principal solicitor, National Association of Community Legal Centres, *Hansard*, 20 August 2019, p. 50; Ms Romola Hollywood, Director, Policy and Advocacy, People with Disability Australia, *Hansard*, 20 August 2019, p. 54; Mr Craig Gear, Older Persons Advocacy Network, *Hansard*, 20 August 2019, p. 55; Relationships Australia, *Submission 17*, p. 1; Office of the Public Guardian (Queensland), *Submission 1*, p. 9; National Association of Community Legal Centres, *Submission 4*, p. 1; and The Public Advocate (Queensland), *Submission 7*, p. 8.

- prohibition against torture and other cruel, inhuman or degrading treatment or punishment;
- right to liberty and security;
- right to health; and
- rights of persons with disabilities.

3.45 Ms Elaine Pearson, Australia Director of Human Rights Watch, stated that the instrument violates the right to health, the prohibition against cruel, inhuman or degrading treatment, the right to liberty and security of person, and, pursuant to the Convention on the Rights of Persons with Disabilities, the right to be free from violence, exploitation and abuse, and the right to integrity of the person.[101] She noted that international standards and United Nations experts and special rapporteurs suggest that laws allowing for chemical restraint should be repealed.[102]

3.46 Aged and Disability Advocacy Australia raised particular concerns about whether these measures breach Australia's obligations under articles 12, 14, 15 and 19 of the United Nations Convention on the Rights of People with a Disability.[103] Dr Juanita Breen, of the Wicking Dementia Research and Education Centre, and Professor Joseph Ibrahim, of the Health law and Ageing Research Unit at Monash University, similarly argued that the measures discriminate against the elderly, including because they purport to apply a less onerous regulatory regime than the regime applying under the National Disability Insurance Scheme, and because elderly people have limited capacity to contribute to the discussion around the regime.[104]

3.47 Ms Natalie Siegel-Brown, Queensland Public Guardian, posited that while these measures represent an attempt to regulate restraint, they in fact 'regress the recognition of human rights for people living in aged care', and create more problems than they may have solved.[105] Mr Bill Mitchell of the National Association

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101 Ms Elaine Pearson, Australia Director, Human Rights Watch, *Hansard*, 20 August 2019, p. 13. See also Human Rights Watch, *Fading Away: How Aged Care Facilities in Australia Chemically Restrain Older People with Dementia* (2019) p. 4.

102 Ms Elaine Pearson, Australia Director, Human Rights Watch, *Hansard*, 20 August 2019, p. 15.

103 Aged and Disability Advocacy Australia, *Submission 2,* p. 1.

104 Dr Juanita Breen, Senior Lecturer, Wicking Dementia Research and Education Centre, University of Tasmania, and Professor Joseph Ibrahim, Head, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University, *Hansard*, 20 August 2019, p. 21.

105 Ms Natalie Siegel-Brown, Queensland Public Guardian, *Hansard*, 20 August 2019, p. 4. See also comments by Dr Kaele Stokes, Executive Director, Advocacy and Research, Dementia Australia; Ms Romola Hollywood, Director, Policy and Advocacy, People with Disability Australia; and Mr Craig Gear, Chief Executive Officer, Older Persons Advocacy Network, *Hansard*, 20 August 2019, p. 58.

of Community Legal Centres agreed, arguing that these principles 'may legitimise the longstanding poor use of restraints', thereby making the situation worse.[106]

3.48 A number of submitters and witnesses recommended that this instrument be disallowed,[107] and that a process of thorough consultation with stakeholders take place before the implementation of any new measures. Ms Elaine Pearson of Human Rights Watch argued that this instrument should be replaced with legislation following consultation with groups working on aged care, working with older people, and people living in the facilities themselves.[108]

Disparity with rules on restraints under the National Disability Insurance Scheme

3.49 Several submitters and witnesses raised concerns about the disparity between the instrument and the regulatory framework established under the National Disability Insurance Scheme (Restrictive Practice and Behaviour Support) Rules 2018 (NDIS rules). Ms Beth Walker, Northern Territory Public Guardian, argued:

> Consistency across service sectors is critical to achieve the reduction and elimination of restrictive practices. There is a clear discord between the level of regulation and authorisation of restrictive practices for NDIS participants compared to that provided by the principles for aged-care consumers across Australia.[109]

3.50 Professor Joseph Ibrahim of the Health Law and Ageing Research Unit at Monash University commented that the lower level of protection provided by the instrument when compared to the NDIS rules was unjustifiable and he 'would also be advocating that the NDIS should expand to people over the age of 65 because, if I'm 65 with a disability, I am disadvantaged and discriminated against in Australia.'[110] Ms Romola Hollywood from People with Disability Australia also argued '[i]f we just

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106 Mr Bill Mitchell, Principal Solicitor, National Association of Community Legal Centres, *Hansard*, 20 August 2019, p. 50. Mr Bill Mitchell also raises broader concerns about the Aged Care Act and associated provisions which frame older persons protections in terms of 'consumer protection framework', which he states does not reflect the vulnerabilities and relatives of elderly people.

107 Dr Juanita Breen, Senior Lecturer, Wicking Dementia Research and Education Centre, University of Tasmania, and Professor Joseph Ibrahim, Head, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University, *Hansard*, 20 August 2019, p. 21; Mr Geoff Rowe, Chief Executive Officer, Aged and Disability Advocacy Australia, *Hansard*, 20 August 2019, p. 49; Mr Bill Mitchell, Principal Solicitor, National Association of Community Legal Centres, *Hansard*, 20 August 2019, p. 53; Office of the Public Guardian (Queensland), *Submission 1*, p. 4; and Aged and Disability Advocacy Australia, *Submission 1*, p. 6; and Aged Care Crisis, *Submission 15*, p. 3.

108 Ms Elaine Pearson, Australia Director, Human Rights Watch, *Hansard*, 20 August 2019, p. 14.

109 Ms Beth Walker, Northern Territory Public Guardian, *Hansard*, 20 August 2019, p. 4.

110 Professor Joseph Ibrahim, Head, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University, *Hansard*, 20 August 2019, p. 21.

work from the assumption that many people who are using aged-care services or living in aged-care residences may have disability, then we should be taking an approach that is consistent.'[111]

3.51 A similar view was expressed in the Interim Report of the Royal Commission into Aged Care Quality and Safety, which notes that the instrument 'falls well short' of the approach taken under the NDIS rules, and that 'there appears to be no justification in this case for inconsistency in protection between sectors. The aged care system has fallen behind, to the significant detriment of people who are subjected to unjustified chemical and physical restraint.'[112]

3.52 Several submitters and witnesses also raised concerns about the vagueness of many of the terms in the instrument, particularly when compared with the definitions set out in the NDIS rules. The Office of the Public Guardian of Queensland argued that the definition of 'physical restraint' is broad and all-compassing, including 'any restraint' other than a chemical one.[113] It proposed that this definition be contrasted with the more extensive detail provided pursuant to the NDIS rules, 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 both at the Commonwealth and state level.[114]

Department of Health's position

3.53 Representatives from the Department of Health appeared before the inquiry at the hearing in Sydney on 20 August 2019, and the committee requested further information in a follow up letter dated 28 August 2019.[115] The department's responses, in relation to key issues of concern with the instrument, are set out below.

Informed consent for physical restraint

3.54 In its follow up letter to the Department of Health, the committee asked for clarification of when consent for the use of physical restraint could be sought from the representative of an aged care consumer rather than the consumer

111 Ms Romola Hollywood, Director, Policy and Advocacy, People with Disability Australia, *Hansard*, 20 August 2019, p. 58.

112 Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect, Volume 1* (31 October 2019), p. 215.

113 Office of the Public Guardian (Queensland), *Submission 1*, p. 6.

114 Office of the Public Guardian (Queensland), *Submission 1*, p. 6.

115 See Parliamentary Joint Committee on Human Rights, Letter sent to the Department of Health from the committee asking additional questions, 28 August 2019.

themselves.[116] The department advised that consent should be sought from a representative '[w]hen the approved provider…has determined that the person cannot give their own fully informed consent'.[117]

3.55 The committee also asked the department to clarify who can decide which person will ultimately be deemed to be the consumer's representative, if more than one person qualifies as a consumer's representative under the instrument, and the basis on which this decision would be made.[118] In response, the department advised:

> While some consumers may have an appointed legal representative, in practice relationships of support may operate on an informal level.
>
> The meaning of 'representative' within the Instrument is intended to provide for the operation of practical decision-making arrangements.[119]

3.56 The committee also asked the department to clarify how long consent to the use of physical restraint would be valid for, in order to understand whether it would be necessary for an approved provider to obtain consent each time a physical restraint is used and how frequently this requirement would generally arise.[120] The department advised:

> Under the Instrument, the requirements (including informed consent) of section 15F must be met in relation to each specific 'use' of restraint. For example, if bedrails are used because a consumer is experiencing side effects while on antibiotics for 14 days, the 'use of restraint' is the two-week period while the care recipient is on antibiotics.[121]

Regulation of chemical restraint

3.57 At the hearing, officers from the department were asked why consent was not required for the administration of chemical restraints.[122] In response, the department advised that '[t]he decision to prescribe a medication or a chemical substance that is called chemical restraint is a decision of the health practitioner who is going to prescribe that medication for that person.'[123]

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116 Parliamentary Joint Committee on Human Rights, Letter sent to the Department of Health from the committee asking additional questions, 28 August 2019.

117 Department of Health, Answers to Questions on Notice No. 4, 10 September 2019.

118 Parliamentary Joint Committee on Human Rights, Letter sent to the Department of Health from the committee asking additional questions, 28 August 2019.

119 Department of Health, Answers to Questions on Notice No. 4, 10 September 2019.

120 Parliamentary Joint Committee on Human Rights, Letter sent to the Department of Health from the committee asking additional questions, 28 August 2019.

121 Department of Health, Answers to Questions on Notice No. 4, 10 September 2019.

122 Senator Nick McKim, *Hansard*, 20 August 2019, p. 69.

123 Dr Bernie Towler, Principal Medical Adviser, Ageing and Aged Care, Department of Health, *Hansard*, 20 August 2019, p. 69.

3.58 The committee sought further advice from the department as to why approved providers were not required to obtain informed consent from consumers prior to the application of chemical restraint, or, at a minimum, to confirm and document that consent has been provided to the prescriber before chemical restraints are applied. In response, the department advised the committee that it is not the responsibility of approved providers to seek informed consent with respect to chemical restraint—'that is the clear responsibility of the prescriber.'[124] The department elaborated:

> The decision was that this regulation is really about approved providers. The Aged Care Act is focused on the actions of providers, and that's where this kind of regulation is focused. It talks about what the responsibilities are of an approved provider. There are other things that capture the responsibilities of prescribers, such as state and territory legislation and general law.[125]

3.59 It further advised the committee that, in lieu of further regulating approved providers, '[t]he requirement for the provider to inform the consumer's representative is a practical and enforceable condition'.[126]

3.60 Specific information was provided about the regulation of prescribers by Dr Bernie Towler, Principal Medical Adviser, Ageing and Aged Care, Department of Health:

> They need to be registered in the first place and then for ongoing practice, and be governed by their medical boards, and that includes medication management. Doctors and nurse practitioners, if it's within their scope of practice to prescribe these kinds of medications, are expected to adhere to appropriate behaviour. They're accountable for that behaviour; they can be sued for that behaviour; they can be struck off by their medical boards.[127]

3.61 The department also advised that 'there are a number of pieces of regulation in general law which require, particularly for chemical restraint, informed consent, and other things are given'.[128] In response to questions on notice, the department provided further information about the detail of this regulation:

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124 Ms Amy Laffan, Assistant Secretary, Aged Care Reform and Compliance Division, Department of Health, *Hansard*, 20 August 2019, p. 68.

125 Ms Amy Laffan, Assistant Secretary, Aged Care Reform and Compliance Division, Department of Health, *Hansard*, 20 August 2019, p. 68.

126 Department of Health, Answers to Questions on Notice No. 5, 10 September 2019.

127 Dr Bernie Towler, Principal Medical Adviser, Ageing and Aged Care, Department of Health, *Hansard*, 20 August 2019, p. 68.

128 Ms Amy Laffan, Assistant Secretary, Aged Care Reform and Compliance Division, Department of Health, *Hansard*, 20 August 2019, p. 67.

> The National Registration and Accreditation Scheme is established through complementary legislation in each state and territory through the Health Practitioner Regulations National Law Act (the National Law) and is responsible for the regulation of the medical and nursing professions.
>
> Both of these professions are regulated by their respective boards; the Medical Board of Australia (MBA) and the Nursing and Midwifery Board of Australia (NMBA). Their role includes setting of standards and codes to provide guidance to their professions about what is expected of their practice. All registration standards, codes and guidelines developed by a National Board are admissible in proceedings under the National Law.
>
> Additionally, medical practitioners and nurse practitioners are required to seek informed consent before using restraint on a consumer under the general law. Otherwise such conduct would amount to an unlawful assault or trespass against the consumer. Accordingly, civil and/or criminal action under the State or Territory law may be taken should the practitioner fail to seek such consent.[129]

3.62 At the hearing, the department was also asked why the use of alternatives to chemical restraint 'are not explicitly required' in the instrument.[130] The department explained that this is required 'on the legislative front', and audited through the Aged Care Quality and Safety Commission.[131] It was also asked to explain why it was relying on existing regulation rather than further regulating chemical restraint in the instrument, given that the existing regulation 'has resulted in innumerable horror stories through the aged-care network in this country of people being unreasonably restrained'.[132] The department responded:

> You are absolutely right; we have a problem out there and we are the first to say that. It has been a problem in the face of lots of literature for a long period of time now…[However] we haven't put it in the Aged Care Act, in this legislative instrument, because the instrument regulates providers. We're not for a minute saying that there isn't a problem, but it needs to be addressed in a different way. We have a suite of projects and work underway to address the chemical restraint problem in a different way. We can't do that under this particular instrument, because this instrument is under the Aged Care Act, which regulates providers, not the prescribers, not the doctors, not the nurse practitioners.[133]

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129 Department of Health, Answers to Questions on Notice No. 5, 10 September 2019.

130 Mr Graham Perrett MP, *Hansard*, 20 August 2019, p. 70.

131 Ms Amy Laffan, Assistant Secretary, Aged Care Reform and Compliance Division, Department of Health, *Hansard*, 20 August 2019, p. 70.

132 Senator Nick McKim, *Hansard*, 20 August 2019, p. 73.

133 Dr Bernie Towler, Principal Medical Adviser, Ageing and Aged Care, Department of Health, *Hansard*, 20 August 2019, p. 73.

3.63 On Thursday 31 October 2019, the Royal Commission into Aged Care Quality and Safety handed down its interim report. In response to a number of its findings in relation to the use of chemical restraints in residential aged care, the Hon. Greg Hunt MP, Minister for Health, secured an agreement from the Council of Australian Governments' Health Ministers to make the safe and quality use of medicine in residential aged care a national priority.[134] Mr Hunt also indicated that the government intends to take 'stronger action' in relation to reducing the use of psychotropic drugs for management purposes, and that the government considers 'the understanding and role of families, [and] the ability to make sure that we have checks and balance, are critical.'[135]

Minimising and eliminating the use of restraints

3.64 At the hearing, the department was asked why there is 'no express requirement that restraints be used only as a last resort and be in proportion to the potential negative consequences of risk or harm?'[136] The department explained that 'the conditions we require be met altogether bundle to equal as "last resort"' and that this requirement is 'mentioned a number of times in the explanatory statement and all of our communications.'[137]

3.65 The department was also asked whether the instrument's objective was to totally eliminate the use of restrictive practices in residential aged care facilities.[138] The department responded that this is 'not government policy. The policy is to minimise the use of restraint, and that restraint can only be used once certain conditions are met.'[139]

3.66 The department was asked how it expects to achieve the outcome of minimising the use of restraints, and what evidence was used in developing the instrument.[140] The department responded that, in February 2019, it 'convened a Key Stakeholder Working Group, to discuss how regulation could be strengthened to minimise the use of physical and chemical restraint in residential aged care.'[141] 'The

134 The Hon. Greg Hunt MP, Minister for Health, *Insiders Transcript*, (3 November 2019), available at: https://www.abc.net.au/insiders/greg-hunt-joins-insiders/11667260.

135 The Hon. Greg Hunt MP, Minister for Health, *Insiders Transcript*, (3 November 2019), available at: https://www.abc.net.au/insiders/greg-hunt-joins-insiders/11667260.

136 Mr Graham Perrett MP, *Hansard*, 20 August 2019, p. 66.

137 Ms Amy Laffan, Assistant Secretary, Aged Care Reform and Compliance Division, Department of Health, *Hansard*, 20 August 2019, p. 66.

138 Mr Graham Perrett MP, *Hansard*, 20 August 2019, p. 66.

139 Ms Amy Laffan, Assistant Secretary, Aged Care Reform and Compliance Division, Department of Health, *Hansard*, 20 August 2019, p. 66.

140 Mr Graham Perrett MP, *Hansard*, 20 August 2019, p. 70.

141 Department of Health, Answers to Questions on Notice No. 2 and 6, 10 September 2019.

Consultation process included the circulation of relevant papers by the department and Key Stakeholder Working Group meetings by teleconference on 4 and 18 March 2019.'[142] The department also stated that it will be 'working closely with the Australian Aged Care Quality and Safety Commission, looking into non-compliance rates of meeting the standards and those sorts of things to track whether restraint is reduced.'[143]

142 Department of Health, Answers to Questions on Notice No. 2, 10 September 2019.

143 Ms Amy Laffan, Assistant Secretary, Aged Care Reform and Compliance Division, Department of Health, *Hansard*, 20 August 2019, p. 70.

Chapter 4

Human rights assessment

Legal vagueness

4.1 As evidenced by the submissions and evidence to this inquiry, on the face of it the instrument appears to authorise approved providers to use physical and chemical restraints in a way that goes beyond what was previously authorised. Considerable concerns have been raised with the committee that rather than minimising the use of restraints, the instrument in fact encourages an increase in their use.

4.2 In particular, on first impressions, the instrument appears to authorise the use of physical restraints so long as a 'representative' has consented to this, yet the definition of 'representative' would appear to include persons who would otherwise not be legally authorised to provide such consent. Neither the instrument, nor its explanatory materials, explains when an approved provider can seek consent from a person's 'representative' and it remains unclear how conflicting claims as to who is the relevant representative are to be resolved. The department advised that the meaning of 'representative' is intended to provide for the operation of 'practical decision-making arrangements',[1] making it unclear how this conforms with the obligation to comply with state and territory legislation governing substitute decision-making.[2] Questions also remain as to how long consent to the use of physical restraint is valid for. While the department advised that consent must be met for each specific 'use' of restraint (such as a resident experiencing side effects from a 14 day course of antibiotics),[3] it is unclear how a period of use would be determined in relation to the use of physical restraints to manage behaviour associated with dementia, given these behaviours might take place over a much longer period of time.

4.3 In addition, the instrument and its explanatory materials appear to authorise the use of chemical restraint without the prior informed consent of the aged care resident or their legally authorised representative and without first requiring that alternative approaches be exhausted.

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1 Department of Health, Answers to Questions on Notice No. 4, 10 September 2019.

2 See, subsection 5(3) of the Quality of Care Principles 2014 and see for example, *Medical Treatment Planning and Decisions Act 2016* (Vic), sections 1, 4, 26, 50; *Guardianship Act 1987* (NSW), sections 6E-F; *Guardianship and Administration Act 2000* (Qld), sections 11, 65, 66; *Consent to Medical Treatment and Palliative Care Act 1995* (SA), Part 2A; *Guardianship and Administration Act 1995* (Tas) sections 25, 39; *Guardianship and Administration Act 1990* (WA), section 45, Pt 9D.

3 Department of Health, Answers to Questions on Notice No. 4, 10 September 2019.

4.4 However, the instrument also provides that the new provisions do not affect the operation of any law of a state or territory in relation to restraint.[4] The explanatory statement to the instrument does not explain what this means in practice, but the evidence provided to the committee from the department is that existing laws regulating restraint—which require prior informed consent before restraint is used—continue to apply. As set out in Chapter 2, restrictive practices are regulated under a complex interplay of general law, and Commonwealth, state and territory laws and guidelines. These include the regulation and accreditation of health practitioners and health care workers including personal care workers which require such persons to ensure that consent has been obtained prior to the provision of a treatment or service (including the use of restraint). The common law of assault and trespass also provides that health care workers must obtain the informed consent of a resident prior to causing force to be applied to the body or clothing of another, or to providing medical treatment, except in the case of an emergency. In addition, state and territory guardianship law determines who can provide lawful consent to medical treatment, or the use of restraint, on behalf of another, and regulates when and how this power can be exercised.

4.5 As such, it appears that this instrument, by adding a layer of regulation on approved providers while not affecting existing prohibitions on the use of restraint, may not directly limit human rights.

4.6 However, it is also apparent from the evidence submitted to the inquiry as set out in Chapter 3, and the findings of the Interim Report of the Royal Commission into Aged Care Quality and Safety,[5] that the instrument has created widespread confusion regarding the obligations of approved providers.

4.7 While Australian law has no general doctrine of vagueness that would invalidate vague legislation,[6] the High Court has found that delegated legislation can be void if its interpretation results in uncertainty as to the conduct which is prohibited (or authorised).[7] Although this instrument may not meet such a threshold of vagueness, the High Court has found that vagueness remains a significant issue in considering the 'practical operation and effect' of legislation.[8] In considering the

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4 See section 15E of the instrument. See also subsection 5(3) of the Quality of Care Principles 2014 (regarding the definition of 'representative').

5 Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect, Volume 1* (31 October 2019), p. 209.

6 *Brown v Tasmania* (2017) 261 CLR 328 (Kiefel CJ, Bell and Keane JJ), [148]-[149]; (Gordon J) [306].

7 See, for example, *King Gee Clothing Co Pty Ltd v Commonwealth* [1945] HCA 23; (1945) 71 CLR 184; *Cann's Pty Ltd v Commonwealth* [1946] HCA 5; (1946) CLR 210.

8 *Brown v Tasmania* (2017) 261 CLR 328 (Kiefel CJ, Bell and Keane JJ), [37], [77] and [79], [117]-[118] and [148]-[151].

impact of legislation on rights and freedoms, for example, the High Court has found that it is this *practical operation and effect* of any impugned measures that must be justified, regardless of any ultimate judicial interpretation of their proper construction.[9]

4.8 Following this reasoning, the confusion surrounding the practical operation and effect of the instrument, and what is, and is not, authorised by it, may have also lead to confusion about the permissibility of the administration of both physical and chemical restraints being used in residential aged care facilities without the informed consent of residents, or their legally authorised representatives, and without first exhausting all alternatives. On this basis, the instrument may engage and limit a number of human rights, including the absolute prohibition on torture, cruel, inhuman or degrading treatment or punishment; the rights to health, privacy and liberty; and the right to equality and non-discrimination and rights of persons with disabilities.

Prohibition on torture, cruel, inhuman or degrading treatment or punishment

4.9 Australia has an obligation not to subject any person to torture or to cruel, inhuman or degrading treatment or punishment.[10] This prohibition is absolute and may never be subject to any limitations. By prescribing the circumstances in which physical or chemical restraints may be used in aged care settings and in adding a layer of confusion as to when restraint may be used, the instrument may engage Australia's absolute obligation not to subject persons to torture, cruel, inhuman or degrading treatment or punishment.

4.10 The committee asked the department whether the instrument engages Australia's obligations under the Convention against Torture and other Cruel, Inhuman, Degrading Treatment or Punishment. In response, the department advised:

> The Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (the Convention) applies where the perpetrator is a public official or person acting in an official capacity. The Quality of Care Amendment (Minimising the Use of Restraints) Principles (the Instrument), made under the *Aged Care Act 1997* (the Act), regulates approved providers of aged care. The Australian Government implemented the requirements under the Convention through the *Crimes (Torture) Act 1988*.
>
> The Instrument is designed to reduce the use of such restraints by an approved provider in relation to a consumer of aged care services.

9 *Brown v Tasmania* (2017) 261 CLR 328 (Kiefel CJ, Bell and Keane JJ), [37], [77] and [79], [117]-[118] and [148]-[151].

10 International Covenant on Civil and Political Rights (ICCPR), article 7; Convention against Torture and other Cruel, Inhuman, Degrading Treatment or Punishment (CAT), articles 3-5.

> As such, approved providers operate in a context that is different from a custodial or other similar situation in which the Convention would apply. In order to consider the application of the Convention, one needs to consider the terms of the Convention itself. It defines torture as a person in an official capacity inflicting severe pain or suffering on a person as a means of obtaining information or a confession, punishing a person for an act committed, or intimidating or coercing someone on discriminatory grounds.
>
> Such a situation seems unlikely to arise, as approved providers are generally private entities. Aged care services are not staffed by persons acting in an official capacity, let alone persons acting in an official capacity to inflict severe pain or suffering on a person as a means of obtaining information or a confession, punishing a person for an act committed, or intimidating or coercing someone on discriminatory grounds within the terms of the Convention.

4.11 However, the obligations imposed on states under the Convention extend to taking 'effective legislative, administrative, judicial or other measures to *prevent* acts of torture in any territory under its jurisdiction.'[11] The United Nations (UN) Committee against Torture has clarified that this obligation to 'prohibit, prevent and redress torture and ill-treatment' applies 'in all contexts of custody or control…[including] institutions that engage in *the care of…the aged,* the mentally ill or disabled…where the failure of the State to intervene encourages and enhances the danger of *privately inflicted harm*'.[12] The UN Committee against Torture has further clarified that a failure by the State 'to exercise due diligence to prevent, investigate, prosecute and punish' private actors where the state knows or has 'reasonable grounds to believe that acts of torture or ill-treatment are being committed' is a breach of its obligations under the Convention.[13]

Eliminating restraint

4.12 The UN Committee on the Rights of Persons with Disabilities has stated that Australia's use of restrictive practices (which includes chemical and physical restraints) on persons with disability raises concerns in relation to freedom from torture and cruel, inhuman or degrading treatment or punishment and has recommended that Australia take immediate steps to end such practices.[14] The UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or

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11 CAT, article 2(1) [emphasis added].

12 UN (United Nations) Committee on Torture, *General Comment No 2: Implementation of article 2 by States parties* (2008) [15] [emphasis added].

13 UN Committee on Torture, *General Comment No 2: Implementation of article 2 by States parties* (2008) [18].

14 UN Committee on the Rights of Persons with Disabilities, *Concluding observations on the initial report of Australia,* CRPD/C/AUS/CO1 (2013) [35]-[36].

Punishment has also raised concerns and called for a ban on the use of restraints in the health-care context, noting that such restraint may constitute torture and ill-treatment in certain circumstances.[15]

4.13 The instrument does not contain a clear objective of eliminating the use of restrictive practices in residential aged care facilities, nor does it explicitly require that restraints only be used as a last resort. As noted in Chapter 3, the department advised the committee that it is not government policy to eliminate the use of restraints, but that the objective of only using restraints as a last resort is effectively required by the instrument.[16] However, while the instrument requires that alternatives to the use of physical restraint (but not chemical) have been used to the extent possible,[17] and *after* the use of the restraint an approved provider must document whether any alternatives to physical and chemical restraint were used,[18] this does not equate to a requirement that restraints only be used as a last resort.

Rights to health, privacy and liberty

4.14 In adding a layer of confusion as to when physical and chemical restraint may be used, which may increase its inappropriate use, this may also engage and limit the rights to health, privacy and liberty, particularly in circumstances where those restraints are used without the consumer's informed consent.

4.15 The right to health includes the right to be free from non-consensual medical treatment.[19] The right to privacy similarly includes the right to personal autonomy and physical and psychological integrity, and extends to protecting a person's bodily integrity against compulsory procedures.[20] No person with disabilities shall be subjected to arbitrary or unlawful interference with their privacy.[21]

4.16 The right to liberty prohibits states from depriving a person of their liberty except in accordance with the law, and provides that no one shall be subject to

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15 UN Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez*, A/HRC/22/53 (2013) [63]; UN General Assembly, *Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak*, A/63/175 (2008) [55].

16 Ms Amy Laffan, Assistant Secretary, Aged Care Reform and Compliance Division, Department of Health, *Hansard*, 20 August 2019, p. 66; Dr Bernie Towler, Principal Medical Adviser, Ageing and Aged Care, Department of Health, *Hansard*, 20 August 2019, p. 66.

17 Subsection 15F(1)(b) of the instrument.

18 Subsections 15F(2)(c) and 15G(2)(b)(ii) of the instrument.

19 International Covenant on Economic, Social and Cultural Rights (ICESCR), article 12. See UN Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (2000) [8].

20 ICCPR, article 17.

21 CRPD, article 22.

arbitrary detention.[22] The existence of a disability shall also, in no case, justify a deprivation of liberty.[23] The definition of 'restraint' in the instrument, as set out in Chapter 2, would include intentional restrictions of voluntary movement or behaviour by the use of a device, or removal of mobility aids, or physical force, and limiting a consumer to a particular environment.[24] The right to liberty may therefore be engaged and limited insofar as the instrument seeks to regulate rather than eliminate these practices.

Right to equality and non-discrimination of persons with disabilities

4.17 The use of physical and chemical restraints also appears to engage and limit the rights to equality and non-discrimination on the basis of age and disability, and the rights of persons with disabilities. These rights are potentially limited in circumstances where restraints are used without the consumer's informed consent and potentially by the different level of protection that is provided under the instrument when compared to those that apply to persons under the age of 65 under the NDIS rules.[25]

4.18 The right to equality and non-discrimination provides that everyone is entitled to enjoy their rights without discrimination of any kind, and that all people are equal before the law and entitled without discrimination to equal and non-discriminatory protection of the law. 'Discrimination' under articles 2 and 26 of the International Covenant on Civil and Political Rights (ICCPR) and article 2(2) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) encompasses a distinction based on a personal attribute (for example, age or disability),[26] which has either the purpose ('direct' discrimination), or the effect ('indirect' discrimination), of adversely affecting human rights.[27]

4.19 The rights of persons with disabilities, as set out in the Convention on the Rights of Persons with Disabilities (CRPD), include the right to equal recognition

22 ICCPR, article 9. The notion of 'arbitrariness' includes elements of inappropriateness, injustice and lack of predictability.

23 CRPD, article 14.

24 Explanatory statement, p. 4.

25 See Chapters 2 and 3: paragraphs [2.35] to [2.39] and [3.47] to [3.49].

26 The prohibited grounds of discrimination are race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Under 'other status' age and disability have been held to qualify as prohibited grounds. See UN Committee on Economic, Social and Cultural Rights*, General Comment 20: Non-discrimination in economic, social and cultural rights* (2009) [28]-[35].

27 UN Human Rights Committee, *General Comment 18: Non-discrimination* (1989).

before the law and to exercise legal capacity;[28] the right to physical and mental integrity on an equal basis with others;[29] and the right to freedom from exploitation, violence and abuse.[30] Australia also has obligations to provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons.[31] The rights of persons with disabilities are relevant insofar as some aged care residents may have physical or mental impairments, such as dementia, that constitute a disability.

4.20 The general principles of the CRPD, as set out in article 3, include respect for inherent dignity and individual autonomy—including the freedom to make one's own choices.[32] This is reinforced by article 12, which provides for the right to equal recognition before the law and to exercise legal capacity,[33] and places an obligation on states parties to provide persons with disabilities with access to support in the exercise of their legal capacity.[34] The committee asked the department whether the instrument provided for supported decision-making arrangements,[35] and the department responded:

> To facilitate the use of supported decision-making arrangements, consumer rights have been set out in the Charter of Aged Care Rights in Schedule 1 to the User Rights Principles 2014 (the User Rights Principles). The Charter has 14 high-level consumer rights, including the right to have control over and make choices about care, personal and social life.
>
> Providers are also required to meet the Aged Care Quality Standards (the Standards), set out under the Quality of Care Principles 2014. Under the Standards, providers are required to demonstrate that each consumer is supported to exercise choice and independence. Consumers who need support to make decisions are expected to be provided with access to the

28 Convention on the Rights of Persons with Disabilities (CRPD), article 12. This includes an obligation to ensure that all measures that relate to legal capacity provide for appropriate and effective safeguards to prevent abuse.

29 CRPD, article 17.

30 CRPD, article 16.

31 CRPD, article 3. See also UN Committee on Economic, Social and Cultural Rights, *General Comment No.14: The Right to the Highest Attainable Standard of Health* (2000) [8].

32 CRPD, article 3.

33 CRPD, article 12(2) and (5).

34 CPRD, article 12(3). CRPD, article 12(4) also imposes an obligation to ensure that all measures that relate to legal capacity provide for appropriate and effective safeguards to prevent abuse.

35 Parliamentary Joint Committee on Human Rights, Letter sent to the Department of Health from the committee asking additional questions, 28 August 2019.

support they need to make, communicate and take part in decisions that affect their lives.[36]

4.21 The committee notes that while these high level principles are important they would likely provide better protection for residents if they were set out in more detail, with specific obligations placed on providers. In addition, the instrument does not require that approved providers seek consent before *administering* chemical restraints. The department has advised that this is because consent is sought by prescribers at the time the prescription is made, and therefore consent at the time it is administered was not considered appropriate.[37] However, as recently noted in the Interim Report of the Royal Commission into Aged Care Quality and Safety,[38] research suggests that psychotropic medication may be significantly overprescribed,[39] and that between 85 per cent and 93.5 per cent of chemical restraint may be being prescribed without the informed consent of a resident's legally empowered representative.[40] Research also suggests that such medication is regularly being prescribed to residents of aged care facilities by fax or telephone, at the request of aged care staff, and that many families are unaware of its use until after it has been administered.[41] In response to these findings, researchers have recommended prompting aged care providers to confirm and document consent prior to *administering* medication.[42]

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36 Department of Health, Answers to Questions on Notice No. 4, 10 September 2019.

37 See paragraphs [3.54] to [3.59].

38 Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect, Volume 1* (31 October 2019), pp. 208-209.

39 Juanita Westbury et al., 'More action needed: Psychotropic prescribing in Australian residential aged care' 53(2) *Australian & New Zealand Journal of Psychiatry* (2019) pp. 136-147; Tiffany Jessop et al., 'Halting Antipsychotic Use in Long-Term care (HALT): a single-arm longitudinal study aiming to reduce inappropriate antipsychotic use in long-term care residents with behavioural and psychological symptoms of dementia' 29(8) *International Psychogeriatric Association* (2017) pp. 1391–1403 at p. 1392.

40 Fleur Harrison et al., 'Inappropriate Prescribing of Antipsychotic Medications in Long Term-Care Residents: The Halt Project' 1(S1) *Innovation in Aging* (2017) p. 968; Nicola Rendina et al., 'Substitute consent for nursing home residents prescribed psychotropic medication' 24 *International Journal of Geriatric Psychiatry* (2009) pp. 226–231 at p. 229. It appears that these studies have only included residents who are not considered capable of providing consent for themselves, which is why the findings only relate to prescriptions without the consent of a resident's legally empowered representative (and not the resident themselves).

41 Juanita Westbury 'Roles for pharmacists in improving the quality use of psychotropic medicines in residential aged care facilities', PhD thesis, University of Tasmania (2011) pp. 171-179, 185, 195-198, 205.

42 Nicola Rendina et al., 'Substitute consent for nursing home residents prescribed psychotropic medication' 24 *International Journal of Geriatric Psychiatry* (2009) pp. 226–231 at p. 231.

Committee view

4.22 The committee strongly supports the intention behind the instrument to seek to limit the use of physical and chemical restraint by approved providers in the aged care setting. The committee considers the use of physical and chemical restraint, particularly without the informed consent of the resident or their legally authorised representative, engages and may limit a number of human rights, including the absolute prohibition on torture, cruel, inhuman or degrading treatment or punishment; the rights to health, privacy and liberty; and the right to equality and non-discrimination and rights of persons with disabilities. As such, the committee welcomes steps to minimise such use, noting that Australia has obligations under international human rights law to take steps to reduce and eliminate such practices.

4.23 However, the committee notes that numerous submitters to the inquiry have raised concerns about how the instrument seeks to regulate the use of physical and chemical restraints, and it would appear that, rather than clarify the role of approved providers, the instrument has created widespread confusion regarding their obligations.[43] In particular, there appears to be confusion as to the role of a resident's 'representative' in providing consent to the use of physical restraints, and whether consent is necessary for the use of chemical restraints. This is particularly concerning given the evidence suggests there is already an over-prescription of psychotropic medication and that the vast majority of the use of chemical restraints in aged care facilities currently occurs without the informed consent of a resident's legally empowered representative.[44]

4.24 The committee considers that while, on the face of it, the instrument appears to engage and limit a number of human rights, existing state and territory laws continue to apply to regulate the use of restraints without informed consent. Nonetheless, in its practical operation and effect, the instrument appears to have created widespread confusion around the legal obligations of approved providers in relation to the use of restraint in residential aged care facilities. Considering the evidence presented to this inquiry, the committee is concerned that this confusion may have created an increased risk that both physical and chemical restraint might be used in residential aged care facilities without the informed consent of residents, or their legally authorised representatives, and without first exhausting all alternatives. As a result, the instrument may engage and limit a number of human rights, including the absolute prohibition on torture, cruel, inhuman or degrading

43 See also Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect, Volume 1* (31 October 2019), p. 209.

44 See also Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect, Volume 1* (31 October 2019), pp. 208-209. See also, in response, the Hon. Greg Hunt MP, Minister for Health, *Insiders Transcript*, (3 November 2019), available at: https://www.abc.net.au/insiders/greg-hunt-joins-insiders/11667260, as noted above at paragraph [3.63].

treatment or punishment; the rights to health, privacy and liberty; and the right to equality and non-discrimination and rights of persons with disabilities.

4.25 In addition, the committee considers that, as currently drafted, the instrument does not require that approved aged-care providers take all reasonable steps to reduce and eliminate the need for the use of restrictive practices. A key issue raised by submitters and witnesses was the lack of requirement that aged care facilities develop positive behaviour support plans which are standard in the disability sector, and that there is disparity between the instrument and the regulatory framework established under the National Disability Insurance Scheme, representing an unjustifiably lower level of protection which may amount to discrimination against older Australians. A similar view was expressed in the Interim Report of the Royal Commission into Aged Care Quality and Safety, which notes that 'there appears to be no justification in this case for inconsistency in protection between sectors.'[45]

Recommendation 1

4.26 In light of the above concerns, the committee recommends, at a minimum, that:

- **the instrument be amended to include a note to clarify that other laws prohibit the use of both physical and chemical restraint without prior informed consent; and**
- **detailed amendments are made to the explanatory materials accompanying the instrument, to clarify how the instrument interacts with state and territory laws, in particular regarding the authorisation of substitute decision-making and the continued obligations for prescribers to exhaust alternative options and obtain informed consent prior to the use of chemical restraint.**

Recommendation 2

4.27 The committee also recommends that the minister undertakes extensive consultation with relevant stakeholders to work towards better regulating the use of restraints in residential aged care facilities, in particular including:

- **an explicit requirement to exhaust alternatives to the use of restraint, including preventative measures and that restraint be used as a last resort (noting the approach taken by the National Disability Insurance Scheme rules);**

45 Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect, Volume 1* (31 October 2019), p. 215.

- **obligations to obtain or confirm informed consent prior to the administration of chemical restraint;**
- **improved oversight of the use of restraints in aged care facilities; and**
- **mandatory reporting requirements for the use of all types of restraint.**

Senator the Hon. Sarah Henderson

Chair

Dissenting Report by Labor and Greens Members

1.1 Australian Labor Party and Australian Greens Members of the Parliamentary Joint Committee on Human Rights (Dissenting Members) consider that the evidence presented in the majority report reflects the evidence given to the committee and understand the intent of the recommendations contained in the majority report; however they do not consider that Recommendation 1 of the majority report will rectify, to the extent necessary to adequately protect the human rights of vulnerable residents in aged care, the concerns raised in the evidence to the committee.

1.2 Dissenting Members consider that, as currently drafted, the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (the instrument**)** engages and limits a number of human rights, including the absolute prohibition on torture, cruel, inhuman or degrading treatment or punishment; the rights to health, privacy and liberty; the right to equality and non-discrimination; and the rights of persons with disabilities.

1.3 Dissenting Members call on the Senate to disallow this instrument.

Overview

1.4 On 29 July 2019 the Parliamentary Joint Committee on Human Rights resolved to conduct a short inquiry into the instrument, as part of its function of examining legislative instruments for compatibility with human rights.

1.5 The Instrument was registered on the Federal Register of Legislation on 2 April 2019, and came into force on 1 July 2019.

1.6 The Instrument seeks to regulate the use of 'physical restraints' and 'chemical restraints' by approved providers of residential care and short-term restorative care in a residential care setting.

1.7 Almost all submissions to the inquiry had serious concerns about the instrument, including that it ignores Australia's human rights obligations and does not sufficiently prevent the inappropriate use of physical and chemical restraint.

1.8 Many submitters have called for the instrument to be disallowed.[1]

Key Concerns

Physical restraint and consent

1.9 Many submitters noted that the instrument requires the care resident, or their 'representative' to consent to the use of physical restraint and were concerned that 'representative' was broadly defined.[2] There were many concerns about the interaction of the instrument with state and territory guardianship laws and existing powers of attorney.

1.10 There is a serious concern that, rather than reducing the use of physical restraints in aged care, the instrument may encourage the use of physical restraint without obtaining appropriate informed consent.

1.11 In evidence to the committee, Dr Colleen Pearce, Public Advocate, Office of the Public Advocate, Victoria, advocated for the disallowance of the Instrument and asked the committee to consider that:

> any authorisation process resting upon the consent of a person or their representative is not the optimal model. The consent model requires point-in-time consent by people who are not experts in restrictive practice usage, and this model does not tend to require or result in meaningful ongoing monitoring of restrictive practice usage. We prefer the situation that applies in Victoria concerning restrictive practice usage by disability services. The external scrutiny model requires restrictive practice usage to be authorised by people who are practised in the field, with authorisation clearly time limited and with clinical oversight of behavioural support plans

1 Dr Juanita Breen, Senior Lecturer, Wicking Dementia Research and Education Centre, University of Tasmania, and Professor Joseph Ibrahim, Head, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University, *Hansard*, 20 August 2019, p. 21; Mr Geoff Rowe, Chief Executive Officer, Aged and Disability Advocacy Australia, *Hansard*, 20 August 2019, p. 49; Mr Bill Mitchell, Principal Solicitor, National Association of Community Legal Centres, *Hansard*, 20 August 2019, p. 53; Office of the Public Guardian (Queensland), *Submission 1*, p. 4; and Aged and Disability Advocacy Australia, *Submission 1*, p. 6; and Aged Care Crisis, *Submission 15*, p. 3.

2 See Parliamentary Joint Committee on Human Rights, *Inquiry report: Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (13 November 2019), [3.4] – [3.7].

> in which the need for restrictive practice usage is articulated and provided by an independent expert, a senior practitioner.[3]

Chemical restraints

1.12 There were significant concerns from submitters that the instrument has no requirement for informed consent to be obtained before chemical restraint is used and this may encourage increased use of chemical restraints.

1.13 Mr Geoff Rowe, Chief Executive Officer, Aged and Disability Advocacy Australia, in his evidence to the committee said that the instrument 'legitimises behaviour that occurs currently.'[4] He referred to evidence to the Royal Commission into Aged Care Quality and Safety (Royal Commission) that an audit of the failed aged care facility at the Gold Coast, Earle Haven, just weeks before its closure, 'identified that 71 per cent of the residents of that facility were subject to chemical restraint at that time.'[5]

1.14 The Royal Commission in its Interim Report identified responding to the 'significant over-reliance on chemical restraint in aged care' as one of three areas requiring 'urgent action'.

Inconsistency with NDIS regulation

1.15 Many submitters referred to the lower level of protection provided by the instrument for aged care residents in comparison to the National Disability Insurance Scheme (NDIS) rules for restrictive practices.[6] The Interim report of the Royal Commission referred to the NDIS rules for restrictive practices and said:

> These include the requirement to engage a 'behaviour support practitioner', whom the National Disability Insurance Scheme Quality and Safeguard Commissioner approves, the development and lodgement of a

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3 Dr Colleen Pearce, Public Advocate, Office of the Public Advocate (Victoria), *Hansard*, 20 August 2019, p.1.

4 Mr Geoff Rowe, Chief Executive Officer, Aged and Disability Advocacy Australia, *Hansard*, 20 August 2019, p. 50.

5 Mr Geoff Rowe, Chief Executive Officer, Aged and Disability Advocacy Australia, *Hansard*, 20 August 2019, pp. 50-51.

6 See Parliamentary Joint Committee on Human Rights, *Inquiry report: Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (13 November 2019), [3.49] – [3.52].

> behaviour support plan, and monthly reporting and oversight by a Senior Practitioner in the Quality and Safeguard Commission.[7]

1.16 The Interim report goes on to say:

> The aged care system has fallen behind, to the significant detriment of people who are subjected to unjustified chemical and physical restraint.[8]

Inconsistency with Australia's human rights obligations

1.17 Australia has an obligation to protect the human rights of all individuals. The issues raised by submitters and the Royal Commission highlight the instrument's deficiencies in upholding Australia's human rights obligations including: the prohibition against torture and other cruel, inhuman or degrading treatment or punishment; right to liberty and security; right to health; and rights of persons with disabilities.

Conclusion

1.18 It is a rare occurrence for a dissenting report to be tabled by members of this committee. Dissenting Members have not taken this step lightly. However, the evidence put before the committee, coupled with the comments contained in the Interim report of the Royal Commission, highlight significant concerns with the instrument. Older Australians living in aged care are some of our most vulnerable citizens and they deserve the same human rights protections as everyone else.

1.19 The Royal Commission's interim report is a terrible indictment on the aged care sector. In the conclusion to their chapter on Restrictive Practices, the Royal Commission says:-

> Behind the use of these restrictive practices lies a history of neglect: neglect to engage adequately with older people to understand their needs and their concerns; neglect in being either time-constrained or unwilling to spend the time with older people to help them manage their changing behaviours so that the need for restraint is obviated; neglect in seeking permission for the use of restraints; and a surprisingly neglectful approach to the use and prolonged use of chemical restraint, which fails to use the

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7 Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect, Volume 1* (31 October 2019), p. 215.

8 Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect, Volume 1* (31 October 2019), p. 215.

> opportunities provided by the Residential Medication Management Review Program.[9]

1.20 The Royal Commission said in relation to the instrument:

> The Principles add to, rather than overcome, concerns regarding regulation of physical and chemical restraint, including on issues of consent.[10]

1.21 Australian Labor Party and Australian Greens Members of the Committee consider that the Instrument should be disallowed and consultation with relevant stakeholders should take place urgently to work towards a human rights based regulatory framework to protect vulnerable older Australians in aged care.

Recommendation 1

1.22 The Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 should be disallowed.

Recommendation 2

1.23 In the short term, urgently reintroduce a new instrument to ensure the provision of informed consent for the use of chemical restraints, reducing the use of restraints, oversight and effective reporting of the use of restraints.

Recommendation 3

1.24 A widespread consultation process should be implemented urgently to determine the best regulatory framework top protect residents of aged care facilities in the use of restraints.

Graham Perrett MP
Deputy Chair
Member for Moreton

Steve Georganas MP
Member for Adelaide

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9 Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect, Volume 1* (31 October 2019), p. 216.

10 Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect, Volume 1* (31 October 2019), p. 209.

Senator Nita Green
Senator for Queensland

Senator Pat Dodson
Senator for Western Australia

Senator Nick McKim
Senator for Tasmania

Appendix 1

Submissions received

1 Office of the Public Guardian (Qld)
2 Aged and Disability Advocacy Australia
3 Public Advocates and Public Guardians – ACT, Qld, NSW, NT, SA, Tas, Vic
4 National Association of Community Legal Centres
5 The Public Advocate (Qld)
6 Leading Ages Services Australia
7 Aged Care Industry Association
8 Human Rights Watch
9 Australian College of Nurse Practitioners
10 Dr Juanita Breen
11 Older Persons Advocacy Network
12 Advocacy for Inclusion
13 Aged Care Quality and Safety Commission
14 Elderlaw
15 Aged Care Crisis
16 Dementia Australia
17 Relationships Australia

Letters received

1 Human Rights Watch (23 May 2019)
2 Office of the Public Advocate (Victoria) (11 July 2019)

Appendix 2

Public hearing

SYDNEY, 20 AUGUST 2019

BOLGER, Ms Christina, Executive Director, Regulatory Policy & Performance, Aged Care Quality and Safety Commission

BREEN, Dr Juanita, Senior Lecturer, Wicking Dementia Research & Education Centre, University of Tasmania

BUCHER, Ms Hazel, Board Member – National Secretary, Australian College of Nurse Practitioners

BURGESS, Ms Mary, Public Advocate, Office of the Public Advocate (QLD)

COAD, Ms Melissa, Executive Projects Coordinator, United Voice

CROUCHER, Emeritus Professor Rosalind, President, Australian Human Rights Commission

DUGGAN, Professor Anne, Chief Medical Officer, Australian Commission on Quality and Safety in Health Care

EGGERT, Dr Marlene, Senior Policy Officer, Leading Aged Services Australia

GEAR, Mr Craig, Chief Executive Officer, Older Persons Advocacy Network

HERKES, Dr Robert, Chief Executive Officer, Australian Commission on Quality and Safety in Health Care

HICKS, Mr Tim, General Manager of Policy and Advocacy, Leading Aged Services Australia

HOLLYWOOD, Ms Romola, Director of Policy and Advocacy, People with Disability Australia

IBRAHIM, Professor Joe, Head, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University

KURRLE, Professor Susan, Member, Australian and New Zealand Society for Geriatric Medicine

LAFFAN, Ms Amy, Assistant Secretary, Aged Care Reform and Compliance Division, Department of Health

LEONARD, Ms Ingrid, Director, Aged Care Reform and Compliance Division, Department of Health

McKAY, Dr Roderick, Fellow, Royal Australian and New Zealand College of Psychiatrists

MITCHELL, Mr Bill, Principal Solicitor of Townsville Community Legal Centre, National Association of Community Legal Centres

NESPOLON, Dr Harry, President, Royal Australian College of General Practitioners

PEARCE, Dr Colleen, Public Advocate, Office of the Public Advocate (Victoria)

PEARSON, Ms Elaine, Australia Director, Human Rights Watch

REEVES, Ms Julie, Federal Professional Officer, Australian Nursing and Midwifery Federation

ROWE, Mr Geoff, Chief Executive Officer, Aged and Disability Advocates Australia

SHEPHERD, Mr Jamie, Professional Officer – Team Leader, Queensland Nurses and Midwives' Union

SIEGEL-BROWN, Ms Natalie, Public Guardian, Office of the Public Guardian (QLD)

STOKES, Dr Kaele, Executive Director, Advocacy and Research, Dementia Australia

TOWLER, Dr Bernie, Principal Medical Adviser, Ageing and Aged Care, Department of Health

WALKER, Ms Beth, Public Guardian, Office of the Public Guardian (NT)

WROTH, Dr Melanie, Chief Clinical Advisor, Aged Care Quality and Safety Commission

Appendix 3

Tabled documents and additional information

Tabled documents

1 Document tabled at a public hearing in Sydney on 20 August 2019 by Dr Colleen Pearce, Public Advocate Vic – statement

2 Document tabled at a public hearing in Sydney on 20 August 2019 by Dr Juanita Breen – graph

3 Document tabled at a public hearing in Sydney on 20 August 2019 by Dr Rodney McKay – briefing note

Additional information

1 Document provided as additional information at a public hearing in Sydney on 20 August 2019 by ANZSGM, Professor Susan Kurrle – MJA Journal article

2 Document provided as additional information at a public hearing in Sydney on 20 August 2019 by ANZSGM, Professor Susan Kurrle – BMC Geriatrics Journal article

3 Document provided as additional information at a public hearing in Sydney on 20 August 2019 by ANZSGM, Professor Susan Kurrle – ANZSGM Position Statement No 2

4 Document provided as additional information at a public hearing in Sydney on 20 August 2019 by ANZSGM, Professor Susan Kurrle – Clinical practice guidelines and principles of care for people with dementia

5 Document provided as additional information at a public hearing in Sydney on 20 August 2019 by the Queensland Nurses and Midwives Union – Queensland Health Chief Psychiatrist Practice Guidelines – Mechanical restraint

6 Document provided as additional information at a public hearing in Sydney on 20 August 2019 by the Queensland Nurses and Midwives Union – Queensland Health Chief Psychiatrist Policy – Mechanical restraint

7 Document provided as additional information at a public hearing in Sydney on 20 August 2019 by the Queensland Nurses and Midwives Union – Queensland Health Chief Psychiatrist Policy – Clinical need for medication

8 Letter sent to the Department of Health from the committee asking additional questions on 28 August 2019

9 Letter from the Department of Health responding to questions from the committee on 10 September 2019

10 Document provided as additional information on 12 September 2019 by the Public Advocate (Queensland) – Response to the Department of Health response to questions from the committee

11 Document provided as additional information on 17 September 2019 by the Public Advocate (Victoria) – Response to the Department of Health response to questions from the committee