Office of the Public Advocate

Submission to the Senate Standing Committee on Community Affairs

Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical standards are maintained and practiced

Introduction

The position of Public Advocate was established by the *Guardianship and Administration Act 2000* (Qld) to undertake systemic advocacy on behalf of people with impaired decision-making capacity in Queensland. The primary role of the Public Advocate is to promote and protect the rights, autonomy and participation of Queenslanders with impaired capacity in all aspects of community life.

I am encouraged to see the various efforts being undertaken to improve the lives of older people, including this current inquiry into the effectiveness of aged care standards. However, I note that this particular inquiry is one of many such federal inquiries in the area of elder abuse generally. Within the last year, I have made submissions to the Australian Law Reform Commission (ALRC) in response to their Issues Paper[1] and Discussion Paper[2] on their inquiry into elder abuse, as well as the Commonwealth Department of Health's *Review of National Aged Care Quality Regulatory Processes*[3] and the *Single Aged Care Quality Framework*.[4]

My concern regarding these various reviews dealing with issues for older people is that, to a large degree, they overlap in their scope. Many of the issues covered in this current inquiry have already been raised in many of the submissions made in response to the other inquiry processes.

While I welcome all efforts to protect older Australians from abuse and poor practices in aged care, I would caution against having too many investigations into the same issues. It is likely that not all of the organisations that have an interest in these issues are necessarily made aware of the various inquiries and calls for submissions. Where they are aware, they must duplicate their efforts in writing submissions. For many small agencies such as ours and non-government organisations, such processes require a significant investment of their limited resources. There is therefore a risk of inquiries not receiving the range of submissions that they should through lack of awareness, resource limitations that require them to make difficult decisions about where to apply those limited resources and 'submission fatigue' generally. Further, there is a real danger that responses by government may end up being duplicated as well, with the possibility that various initiatives resulting from these inquiries overlapping and expending resources that could be better utilised in a singular, more concentrated effort.

Given the intersection of issues being considered by this inquiry with those other inquiries mentioned above, this submission is largely based on previous submissions made to those inquiries. I would also respectfully suggest, if it is not already being contemplated, that the Committee have regard to the submissions made by other organisations and individuals to the

[1] Australian Law Reform Commission, *Elder Abuse Issues Paper* (IP 47) (June 2016).
[2] Australian Law Reform Commission, *Elder Abuse Discussion Paper* (DP 83) (December 2016).
[3] Department of Health (Commonwealth), *Review of National Aged Care Quality Regulatory Processes* (June 2017).
[4] Department of Health (Commonwealth), *Single Aged Care Quality Framework – Draft Aged Care Quality Standards Consultation Paper 2017*.

ALRC and the Commonwealth Department of Health, and to the ALRC's final report for the Elder Abuse Inquiry (tabled in the Australian Parliament 14 June 2017).[5]

Need for regulation of restrictive practices in aged care

On 15 June 2017, World Elder Abuse Awareness Day, I released the paper *Legal frameworks for the use of restrictive practices in residential aged care: An analysis of Australian and international jurisdictions* (see attached).[6] The paper aims to contribute to contemporary discussion about the regulation of restrictive practices in Australian residential aged care settings by exploring the existing laws, policies and practices in Australia and other international jurisdictions.

The paper notes that the use of restrictive practices to manage the challenging behaviours of people supported by the aged and disability sectors has become a key human rights issue in Australia. Detention, seclusion, physical, chemical and mechanical restraint, as well as electronic forms of restraint such as camera surveillance, are regularly used in residential aged care facilities. However, there is currently no legislative framework to regulate these practices. The use of restrictive practices in aged care settings, without legal justification or excuse, is unlawful and amounts to elder abuse.

The absence of a legal framework for the use of restrictive practices in residential aged care services leaves older Australians at risk of having their basic human rights breached by staff who do not have the knowledge or skills to manage challenging behaviours appropriately. Equally, staff in these facilities who are using restrictive practices do not have the protections of legal immunities that would be provided under a formal legislative regime and are at risk of criminal prosecution for unlawful deprivation of liberty or assault, or civil claims for false imprisonment, assault or battery.

In its June 2016 Issues Paper regarding elder abuse,[7] the ALRC also recognised that some restrictive practices can constitute elder abuse, deprive people of their basic legal and human rights and be classified as assault, false imprisonment and/or other civil or criminal acts. The ALRC ultimately recommended in its final report that aged care legislation should regulate the use of restrictive practices in residential aged care.[8]

Therefore, to ensure proper clinical and medical care standards are maintained and practised in the aged care sector, it is submitted that the paper prepared by my office and the findings of the ALRC be considered by the Committee and that it recommend to the Commonwealth Government that it take steps to regulate the use of restrictive practices in residential aged care as a matter of urgency.

[5] Australian Law Reform Commission, *Elder Abuse – A National Legal Response* (ALRC Report 131) (May 2017).
[6] Office of the Public Advocate, *Legal frameworks for the use of restrictive practices in residential aged care: An analysis of Australian and international jurisdictions* (June 2017).
[7] Australian Law Reform Commission, above n 1, 24.
[8] Australian Law Reform Commission, above n 5, Recommendation 4-10.

Review of National Aged Care Quality and Regulatory Processes

I note that this review was commissioned by the Australian government in response to the Oakden Report[9] which detailed failures in the quality of care delivered at the Oakden Older Persons Mental Health Service in South Australia. I have read the Restrictive Practices chapter of that report and note that the Oakden facility was gazetted as an Approved Treatment Centre under the *Mental Health Act 2009* (SA). Accordingly, restrictive practices applied to residents of Oakden (albeit with little regard to treatment standards and legal and reporting requirements), were likely covered by the restrictive practices framework under the Mental Health Act in that State.

However, other older people who are subjected to restrictive practices in residential aged care facilities in South Australia, and other parts of Australia, where those facilities are not regulated under the respective State or Territory mental health regimes (which is the majority of these facilities), are without any legislative regulatory framework or protections.

As noted above, the issue of properly regulating the use of restrictive practices requires immediate attention by the Commonwealth Government and I strongly urge that this be addressed as soon as possible.

Aged care quality standards

As mentioned above, the Commonwealth Department of Health has released the *Single Aged Care Quality Framework – Draft Aged Care Quality Standards Consultation Paper 2017*.[10] In my response to this Consultation Paper, [11] I supported the Australian government's approach to developing a single set of standards that are sufficiently broad for use within all aged care services. A single set of standards should, in theory, reduce the administrative burden on aged care providers and deliver a more consistent and streamlined approach to quality within the sector.

Such standards would clearly improve the effectiveness of the framework around aged care quality assessment and accreditation in protecting the residents from abuse and poor practice.

The numerous references throughout the draft standards to addressing the abuse, neglect and exploitation of older people in formal care were also supported, as was the inclusion of: 1) the focus on consumer needs, goals and preferences, and 2) articulating expected consumer outcomes, provider requirements, and key features of the draft standards.

[9] Groves A et al, *The Oakden Report* (April 2017).
[10] Department of Health (Commonwealth), above n 4.
[11] Office of the Public Advocate, *Submission to the Commonwealth Department of Health – Single Aged Care Quality Framework: Draft Aged Care Quality Standards and options for assessing performance against Aged Care Quality Standards* (April 2017) <http://www.justice.qld.gov.au/__data/assets/pdf_file/0019/526132/20170406-single-aged-care-quality-framework-final.pdf>.

The current processes for quality accreditation/certification of aged care providers are both confusing and onerous. There is clearly a need for a single set of standards that guide quality among all government-funded aged care providers as well as a single, straightforward system of quality accreditation/certification that both reduces the administrative burden on providers and is easily understood by consumers and their supporters.

The importance of effective complaints mechanisms

In its inquiry into elder abuse, the ALRC considered other issues in aged care that are relevant to the current inquiry. In particular, the ALRC examined proposals to expand and enhance reporting and protections for older people in aged care and the adoption of a reportable incidents scheme that requires approved aged care providers to notify reportable incidents to the Aged Care Complaints Commissioner. I supported these proposals.[12] However, I also strongly recommended that such a scheme should require such reports be mandatorily made to State police agencies where there is a suspicion of criminal offending. Further consultation with law enforcement agencies must be undertaken to establish the best way to make these reports, either through a dedicated liaison or more regular channels. Although reports of these incidents could also be passed on to police by the Aged Care Complaints Commissioner, any delay in reporting of offending that could result in criminal prosecution may result in the loss of evidence.

The ALRC ultimately recommended that a national employment screening process be created for Commonwealth-regulated aged care.[13] Such a process would complement a reportable incidents scheme by ensuring that workers who pose unreasonable risks are not employed in roles that allow them access to vulnerable older people.

Further to the above, I submitted to the ALRC during the Issues Paper stage of their inquiry into elder abuse regarding what changes should be made to aged care complaints mechanisms to improve responses to elder abuse.[14]

> *Complaints mechanisms are integral to a comprehensive system of safeguards for older people. A recent project by this office about complaints management systems for adults with impaired decision-making capacity identified a range of barriers that prevent many of these people from having their issues resolved through formal complaints mechanisms.[15] In addition to the usual reasons for not making formal complaints,[16] people with impaired decision-making capacity (including older people with dementia) may experience greater barriers to making complaints for a range of reasons including:*

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[12] Office of the Public Advocate, *Submission to the Australian Law Reform Commission – Elder Abuse Discussion Paper (DP 83)* (March 2017) <http://www.justice.qld.gov.au/__data/assets/pdf_file/0003/515694/submission-alrc-elder-abuse-mar-2017.pdf>.
[13] Australian Law Reform Commission, above n 5, Recommendation 4-9.
[14] Office of the Public Advocate, *Submission to the Australian Law Reform Commission – Elder Abuse Issues Paper* (August 2016) <http://www.justice.qld.gov.au/__data/assets/pdf_file/0007/484450/alrc-submission-final.pdf>.
[15] Office of the Public Advocate (Queensland), *Strengthening Voice: A Scoping Paper About Complaints Management Systems for Adults with Impaired Capacity* (February 2015) 8-15 <http://www.justice.qld.gov.au/public-advocate/activities/current/complaints-management>.
[16] Sarah Cook, *Complaint Management Excellence: Creating Customer Loyalty Through Service Recovery* (electronic version, Kogan Page, 2012); Clay M Voorhees, Michael K Brady and David M Horowitz, 'A Voice from the Silent Masses: An Exploratory and Comparative Analysis of Noncomplainers' (2006) 34(4) *Journal of the Academy of Marketing Science* 514-527.

- *they do not understand their rights;*
- *the process or the entry points for making complaints are less accessible;*
- *not being believed or taken seriously when they do make a complaint;*
- *not being able to manage and present evidence to support their complaint;*[17] *and*
- *those individuals who receive services from others are often reluctant to make complaints for fear of reprisals or withdrawal of services.*[18]

Our complaints management systems project also identified that complaints systems were not always sufficiently responsive to individuals with impaired decision-making capacity who may be unable to take the action necessary to initiate and progress a complaint through to resolution.[19] *These adults frequently required additional support to use complaints systems effectively.*[20] *The type of support that people may require varies, from assistance to identify the need to make a complaint to assisting people with most or all aspects of the complaint-making process, including progressing the complaint to an external complaints agency. This support is not always offered through organisational complaints management systems. This was also observed to be the case for some organisations whose role it was to provide specialist supports to this group.*

These and other issues are likely to significantly reduce the effectiveness of complaints systems for older people who are diagnosed with dementia or other capacity-affecting conditions. Complaints schemes for this group should therefore incorporate mechanisms that maximise accessibility of complaints management systems for people with impaired decision-making capacity and support to actively engage in the complaint-making process. In support of this, the UNCRPD places obligations on state parties to make reasonable adjustments to supports, systems and processes to ensure they are accessible to people with disability.[58] *Our office identified strategies that could be used to strengthen the voices of older and vulnerable Australians who interact with the aged care system.*

These approaches include:

- *prioritising satisfaction;*
- *proactively identifying dissatisfaction;*
- *ensuring access to independent advocacy;*

[17] Office of the Public Advocate, above n 15, 8-10.
[18] See, for example, Alisoun Milne, 'Commentary on Protecting My Mother' (2011) 13(1) *The Journal of Adult Protection* 53-56; Queensland Parents for People with a Disability (QPPD), *Papering Over the Cracks: The Veneer of Prevention* (2005) 39 <http://www.qppd.org/images/docs/ci_report_2005.pdf>.
[19] Office of the Public Advocate, above n 15.
[20] Office of the Public Advocate, above n 15, 28; International sources also identify the importance of support during complaint making, see Healthwatch England, 'Suffering in Silence: Listening to Consumer Experiences of the Health and Social Care Complaints System' (A Healthwatch England Report, October 2014) <http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/complaints-summary_0.pdf>.

- *adopting facilitative and inquisitorial approaches;*
- *guaranteeing safety and freedom from reprisal;*
- *recognising the value of informal complaint-making processes; and*
- *ensuring a responsive system.*[21]

This office's complaints management systems project also highlighted how additional systemic review mechanisms may ameliorate some of the inadequacies of formal complaints management systems. For example, the frequent and on-going presence of external visitors may assist with identifying and raising issues for people with impaired decision-making capacity and progressing them to resolution. Independent advocates can perform similar functions, although engaging their services generally requires proactive effort that may be beyond the capabilities of some people with impaired decision-making capacity.

Mechanisms to provide direct access to independent advocates, rights advisors or professionals who have similar advocacy functions, along with regular engagement with personal visitors and the establishment of an independent and professional community visitor scheme are crucial inclusions to safeguard against abuse. Ensuring that complaints management systems incorporate or link to advocacy and community visitor programs may, also help mitigate against elder abuse in institutional settings such as residential aged care. It should therefore be recognised that, while necessary, complaints schemes are insufficient mechanisms in themselves for protecting older people from abuse and exploitation and must also be complemented by additional safeguards.[22]

Concluding comments

The need to protect residents of aged care facilities from abuse and poor practices and to ensure that proper clinical and medical care standards are practiced and maintained has never seemed more important than at the present time. A larger proportion of the Australian population than ever before is older and ageing, resulting in much higher levels of demand for aged care services and facilities and associated costs. However, in recent months the community has been shocked by reports of terrible abuse and neglect, poor treatment practices and unconscionable financial practices in the residential aged care sector.

Thank you for the opportunity to provide feedback to your Committee regarding the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices in the aged care sector. I trust that the Committee will recommend strict quality standards and complaints systems that will establish a rigorous framework that will protect residents from abuse and neglect. Should the opportunity arise, I

[21] Office of the Public Advocate, above n 15.
[22] Office of the Public Advocate, above n 14, 13-14.

would be pleased to be part of further discussions in relation to these matters or any other issues raised in my submission.

Yours sincerely

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Public Advocate (Queensland)

Office of the Public Advocate

Legal frameworks for the use of restrictive practices in residential aged care: An analysis of Australian and international jurisdictions

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Executive Summary

The use of restrictive practices to manage the challenging behaviours of people in the aged and disability sectors has become a key human rights issue in Australia.[1]

Restrictive practices such as detention, seclusion, restricted access to objects, physical, chemical and mechanical restraint (as well as electronic forms of restraint such as tracking bracelets, camera surveillance, or restrictions on media devices[2]) are regularly used in human service and criminal justice settings, such as disability accommodation and support services, residential aged care facilities, mental health services and prisons.

Restrictive practices are used in these settings despite studies indicating that their use may result in negative physical and psychological effects on the person being restrained[3] and may also constitute a breach of law and human rights.[4]

Some jurisdictions in Australia regulate the use of restrictive practices in the disability and/or mental health sectors.[5] However, the *Aged Care Act 1997* (Cth), which is the primary piece of legislation governing aged care in Australia contains no provisions that address or regulate the use of restrictive practices.[6]

Consequently, the use of restrictive practices in aged care settings, without legal justification or excuse, is unlawful and amounts to elder abuse.[7]

The absence of regulation of restrictive practices in aged care across Australia is concerning for a number of reasons. The number of people with dementia in Australia is expected to increase

[1] Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* Report No 124 (2014) 243.
[2] Alistair R. Niemeijer et al, 'Ethical and practical concerns of surveillance technologies in residential care for people with dementia or intellectual disabilities: An overview of the literature' (2010) 22(7) *International Psychogeriatrics* 1129, 1136.
[3] Sarah Mott, Julia Poole and Marita Kenrick, 'Physical and chemical restraints in acute care: Their potential impact on the rehabilitation of older people' (2005) 11 *International Journal of Nursing Practice* 95, 96; Jenny Gowan and Louis Roller, 'Chemical restraint or pharmacological treatment for abnormal behaviours' (2012) 93 *The Australian Journal of Pharmacy* 58, 60; Jeffrey Chan, Janice LeBel and Lynne Webber, 'The dollars and sense of restraints and seclusion' (2012) 20(1) *Journal of Law and Medicine* 73, 74.
[4] Donal Griffith, 'Substituted decision making: Part 1 When are restraints off the rails?' (2014) 17(2) *Retirement & Estate Planning Bulletin* 1, 1; *Universal Declaration of Human Rights,* GA Res 217A (III), UN GAOR, 3rd sess, 183rd mtg, UN Doc A/810 (10 December 1948); Juan E. Mendez, 'Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment' (A/HRC/22/53, 1 February 2013); The potential for human rights breaches in relation to the use of restrictive practices has been reinforced by the United Nations Committee on the Rights of Persons with Disabilities, which expressed concerns about the use of unregulated restrictive practices in its concluding observations on Australia's initial report under the *Convention on the Rights of Persons With Disabilities* (UNCRPD). See Committee on the Rights of Persons With Disabilities, *Concluding Observations on the Initial Report of Australia* (adopted by the Committee at its tenth session 2-13 September 2013) 5.
[5] See, for example, *Disability Services Act 2006* (Qld) pt 6; *Mental Health Act 2016* (Qld) ch 8.
[6] Michael Williams, John Chesterman and Richard Laufer, 'Consent versus scrutiny: Restricting liberties in post-Bournewood Victoria' (2014) 21(3) *Journal of Law and Medicine* 641, 644; Judy Allen and Tamara Tulich, ''I want to go home now': Restraint decisions for dementia patients in Western Australia' (2015) 33(2) *Law in Context* 1, 4.
[7] It should be noted that not all residents of aged care facilities are elderly people. In the absence of appropriate care facilities for young people with significant care needs, some young people reside in residential aged care facilities.

substantially from around 413,106 in 2017 to 1,100,890 by 2056.[8] Many people in this group will eventually experience the behavioural and psychological symptoms and challenging behaviours associated with dementia.

There is a growing body of research indicating that dementia-related behaviours are often being managed by unregulated restrictive practices,[9] and that restrictive interventions are in widespread use in both formal and informal aged care settings.[10] This is particularly problematic given that more than half of people in residential aged care in Australia have a diagnosis of dementia.[11] Evidence also suggests that some residential aged care staff do not have the knowledge and skills to manage behaviours appropriately,[12] and that the wellbeing of the person being restrained may be negatively affected as a result.[13] It is concerning that the inappropriate use of restraints in aged care facilities in Australia has been a factor in the deaths of some people upon whom the restraints were applied.[14]

In one case, the use of restrictive practices was found to be a breach of the care principles under the *Aged Care Act*.[15]

The increasing numbers of people with dementia and the potential harm that may occur as a result of ad hoc or poorly applied restrictive practices[16] suggest an urgent need to establish a clear legal framework to clarify the legality and appropriate use of restrictive practices in the Australian aged care system.

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[8] Alzheimer's Australia, *Economic Cost of Dementia in Australia 2016-2056* (February 2017) 6.

[9] Sally Borbasi et al, 'A Nurse Practitioner Model of Service Delivery in Caring for People with Dementia' (2010) 36(1-2) *Contemporary Nurse: A Journal for the Australian Nursing Profession (Supplementary Advances in Contemporary Nursing: Workforce and Workplaces)* 49-60; Tanya Davison et al, 'Non-Pharmacological Approaches to Managing Challenging Behaviors Associated with Dementia in Aged Care' (2010) 32(5) InPsych <https://www.psychology.org.au/publications/inpsych/2010/october/davison/>.

[10] See, for example, Janet Timmins, 'Compliance with best practice: implementing the best available evidence in the use of physical restraint in residential aged care' (2008) 6(3) *International Journal of Evidence-Based Healthcare* 345, 345; Cath Roper, Bernadette McSherry and Lisa Brophy, 'Defining seclusion and restraint: Legal and policy definitions versus consumer and carer perspectives' (2015) 23(2) *Journal of Law and Medicine* 297, 298; Sarah N. Hilmer and Danijela Gnjidic, 'Rethinking psychotropics in nursing homes' (2013) 198(2) *Medical Journal of Australia* 77, 77Office of the Public Advocate (SA), 'Annual Report 2012-2013' (2013) 46; Mary Courtney et al, 'Benchmarking clinical indicators of quality for Australian residential aged care facilities' (2010) 34(1) *Australian Health Review* 93, 98. Additionally, in a study of family carers of people with dementia, the use of psychotropic medications was the second most commonly used strategy for managing behavioural and psychological symptoms of dementia. See Kirsten Moore et al 'How do Family Carers Respond to Behavioral and Psychological Symptoms of Dementia?' (2013) 25(5) *International Psychogeriatrics* 743-753.

[11] Australian Institute of Health and Welfare, *Half of Australians in Permanent Residential Aged Care Suffer From Dementia* (4 September 2015) <http://www.aihw.gov.au/media-release-detail/?id=60129552716>.

[12] Sally Borbasi et al, 'A Nurse Practitioner Model of Service Delivery in Caring for People with Dementia' (2010) 36(1-2) *Contemporary Nurse: A Journal for the Australian Nursing Profession (Supplementary Advances in Contemporary Nursing: Workforce and Workplaces)* 49-60.

[13] Nicholas G Castle, 'Mental Health Outcomes and Physical Restraint Use in Nursing Homes {Private}' (2006) 33(6) *Administration and Policy in Mental Health and Mental Health Services Research* 696-704; K Cubit et al, 'Behaviours of Concern in Dementia: A Survey of the Frequency and Impact of Behaviours of Concern in Dementia on Residential Aged Care Staff' (2007) 26(2*) Australasian Journal on Ageing* 64-70.

[14] *Plover v McIndoe* (2000) 2 VR 385; Sarah Farnsworth, Woman dies of heart attack while strapped to toilet (17 August 2011) ABC News<http://www.abc.net.au/news/2011-08-17/seymour-health/2843252>.

[15] *Saitta Pty Ltd v Secretary, Department of Health and Ageing* (2008) 105 ALD 55, at [122]. It is important to note that the application of restrictive practices was not the core matter being determined and the general use of restrictive practices was not explored in detail in the tribunal decision.

[16] For example, behaviour driven by undiagnosed pain may be misinterpreted as a behavioural or psychological symptom of dementia and subsequently 'treated' with inappropriate administration of psychotropic drugs which can lead to complications such as falls, fractures, impaired cognition, and increased risk of death. See Edwin Tan et al, 'Analgesic Use, Pain and Daytime Sedation in People With and Without Dementia in Aged Care Facilities: A Cross-Sectional, Multisite, Epidemiological Study Protocol' (2014) 4(6) *BMJ Open.*

Queensland has a comprehensive restrictive practice regulatory framework for the disability sector (under the *Disability Services Act 2006* (Qld)) with safeguards that require that restrictive practices are only used within a framework of positive behaviour support. A positive behaviour support process requires multi-disciplinary assessments of the person who would be subject to the restrictive practices and their care and support needs, along with the development of a positive behaviour support plan that identifies the person's challenging behaviours and contains strategies for responding positively to those behaviours. The object of the process is that the use of a restrictive practice is to be the least restrictive option, and used for the shortest period necessary, with a view to reducing the use of restrictive practices over time. Ultimately, the restrictive practice must be formally approved before it can be used.[17]

The inclusion of restrictive practices provisions in the *Disability Services Act*, and the introduction of appropriate training for sector workers, has resulted in greater transparency around the use of restrictive practices in Queensland's disability sector. The effect of these initiatives has been increased consistency, professionalism and oversight around the support provided to people whose behaviours may result in harm to themselves or others.

The Australian Law Reform Commission has recognised that the application of some restrictive practices can constitute elder abuse, deprive people of their basic legal and human rights and be classified as assault, false imprisonment and/or other civil or criminal acts.[18] In its June 2016 Issues Paper, released as part of its Elder Abuse Inquiry, the Commission proposed that the *Aged Care Act* be amended to regulate the use of restrictive practices.[19]

[17] *Disability Services Act 2006* (Qld) pt 6 - provisions relating to positive behaviour support and restrictive practices; *Guardianship and Administration Act 2000* (Qld) ch 5B - provisions relating to restrictive practices.
[18] Australian Law Reform Commission, *Elder Abuse Issues Paper* (IP 47) (June 2016) 238.
[19] Ibid.

Introduction

The use of restrictive practices to manage the challenging behaviours of people in the aged and disability sectors has become a key human rights issue in Australia.[1] Detention, seclusion, restricted access to objects, physical, chemical and mechanical restraint (as well as electronic forms of restraint such as tracking bracelets, camera surveillance, or restrictions on media devices[2]) are regularly employed in human service and criminal justice settings, such as disability accommodation and support services, residential aged care facilities, mental health services and prisons. Restrictive practices are used in these settings despite studies indicating that their use may result in negative physical and psychological effects on the person being restrained[3] and may also constitute a breach of law and human rights.[4]

While some jurisdictions in Australia regulate the use of restrictive practices in the disability and/or mental health sectors,[5] the law governing these practices in residential aged care is unclear and, for the most part, non-existent.[6] At present, the *Aged Care Act 1997* (Cth) does not regulate the use of restrictive practices such as chemical, physical and mechanical restraint.

This is concerning for a number of reasons. The number of people with dementia is expected to increase substantially from around 413,106 in 2017 to 1,100,890 by 2056,[7] many of whom will eventually experience the behavioural and psychological symptoms (such as challenging behaviours) associated with dementia. There is a growing body of research indicating that dementia-related behaviours are often being managed by unregulated restrictive practices,[8] and that restrictive interventions are in widespread use in both formal and informal aged care

[1] Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* Report No 124 (2014) 243.
[2] Alistair R. Niemeijer et al, 'Ethical and practical concerns of surveillance technologies in residential care for people with dementia or intellectual disabilities: An overview of the literature' (2010) 22(7) *International Psychogeriatrics* 1129, 1136.
[3] Sarah Mott, Julia Poole and Marita Kenrick, 'Physical and chemical restraints in acute care: Their potential impact on the rehabilitation of older people' (2005) 11 *International Journal of Nursing Practice* 95, 96; Jenny Gowan and Louis Roller, 'Chemical restraint or pharmacological treatment for abnormal behaviours' (2012) 93 *The Australian Journal of Pharmacy* 58, 60; Jeffrey Chan, Janice LeBel and Lynne Webber, 'The dollars and sense of restraints and seclusion' (2012) 20(1) *Journal of Law and Medicine* 73, 74.
[4] Donal Griffith, 'Substituted decision making: Part 1 When are restraints off the rails?' (2014) 17(2) *Retirement & Estate Planning Bulletin* 1, 1; *Universal Declaration of Human Rights,* GA Res 217A (III), UN GAOR, 3rd sess, 183rd mtg, UN Doc A/810 (10 December 1948); Juan E. Mendez, 'Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment' (A/HRC/22/53, 1 February 2013); The potential for human rights breaches in relation to the use of restrictive practices has been reinforced by the United Nations Committee on the Rights of Persons with Disabilities, which expressed concerns about the use of unregulated restrictive practices in its concluding observations on Australia's initial report under the *Convention on the Rights of Persons With Disabilities* (UNCRPD). See Committee on the Rights of Persons With Disabilities, *Concluding Observations on the Initial Report of Australia* (adopted by the Committee at its tenth session 2-13 September 2013) 5.
[5] See, for example, *Disability Services Act 2006* (Qld) pt 6; *Mental Health Act 2016* (Qld) ch 8.
[6] Michael Williams, John Chesterman and Richard Laufer, 'Consent versus scrutiny: Restricting liberties in post-Bournewood Victoria' (2014) 21(3) *Journal of Law and Medicine* 641, 644; Judy Allen and Tamara Tulich, ''I want to go home now': Restraint decisions for dementia patients in Western Australia' (2015) 33(2) *Law in Context* 1, 4.
[7] Alzheimer's Australia, *Economic Cost of Dementia in Australia 2016-2056* (February 2017) 6.
[8] Sally Borbasi et al, 'A Nurse Practitioner Model of Service Delivery in Caring for People with Dementia' (2010) 36(1-2) *Contemporary Nurse: A Journal for the Australian Nursing Profession (Supplementary Advances in Contemporary Nursing: Workforce and Workplaces)* 49-60; Tanya Davison et al, 'Non-Pharmacological Approaches to Managing Challenging Behaviors Associated with Dementia in Aged Care' (2010) 32(5) *InPsych*.

settings.[9] This is particularly problematic given that more than half of people in residential aged care in Australia have a diagnosis of dementia.[10]

Evidence also suggests that some residential aged care staff do not have the knowledge and skills to manage behaviours appropriately,[11] and that the wellbeing of the person being restrained may be negatively affected as a result.[12] It is concerning that the inappropriate use of restraints in aged care facilities in Australia has been a factor in the deaths of some people upon whom the restraints were used.[13]

The increasing numbers of people with dementia and the potential harm that may occur as a result of ad hoc or poorly applied restrictive practices[14] suggest an urgent need to clarify the legality of restrictive practices in the Australian aged care system. Further, restrictive practices should be regulated to achieve a more consistent, evidence- and rights-based approach to responding to dementia-related behaviours.

In its June 2016 *Elder Abuse Issues* Paper, the Australian Law Reform Commission recognised that some restrictive practices can constitute elder abuse, deprive people of their basic legal and human rights and be classified as assault, false imprisonment and/or other civil or criminal acts.[15]

[9] See, for example, Janet Timmins, 'Compliance with best practice: implementing the best available evidence in the use of physical restraint in residential aged care' (2008) 6(3) *International Journal of Evidence-Based Healthcare* 345, 345; Cath Roper, Bernadette McSherry and Lisa Brophy, 'Defining seclusion and restraint: Legal and policy definitions versus consumer and carer perspectives' (2015) 23(2) *Journal of Law and Medicine* 297, 298; Sarah N. Hilmer and Danijela Gnjidic, 'Rethinking psychotropics in nursing homes' (2013) 198(2) *Medical Journal of Australia* 77, 77Office of the Public Advocate (SA), 'Annual Report 2012-2013' (2013) 46; Mary Courtney et al, 'Benchmarking clinical indicators of quality for Australian residential aged care facilities' (2010) 34(1) *Australian Health Review* 93, 98. Additionally, in a study of family carers of people with dementia, the use of psychotropic medications was the second most commonly used strategy for managing behavioural and psychological symptoms of dementia. See Kirsten Moore et al 'How do Family Carers Respond to Behavioral and Psychological Symptoms of Dementia?' (2013) 25(5) *International Psychogeriatrics* 743-753.

[10] Australian Institute of Health and Welfare, *Half of Australians in Permanent Residential Aged Care Suffer From Dementia* (4 September 2015) <http://www.aihw.gov.au/media-release-detail/?id=60129552716>.

[11] See Sally Borbasi et al, 'A Nurse Practitioner Model of Service Delivery in Caring for People with Dementia' (2010) 36(1-2) *Contemporary Nurse: A Journal for the Australian Nursing Profession (Supplementary Advances in Contemporary Nursing: Workforce and Workplaces)* 49-60.

[12] Nicholas G Castle, 'Mental Health Outcomes and Physical Restraint Use in Nursing Homes {Private}' (2006) 33(6) *Administration and Policy in Mental Health and Mental Health Services Research* 696-704; K Cubit et al, 'Behaviours of Concern in Dementia: A Survey of the Frequency and Impact of Behaviours of Concern in Dementia on Residential Aged Care Staff' (2007) 26(2*) Australasian Journal on Ageing* 64-70.

[13] See, for example, *Plover v McIndoe* (2000) 2 VR 385; Sarah Farnsworth, *Woman dies of heart attack while strapped to toilet* (17 August 2011) ABC News <http://www.abc.net.au/news/2011-08-17/seymour-health/2843252>.

[14] For example, behaviour driven by undiagnosed pain may be misinterpreted as a behavioural or psychological symptom of dementia and subsequently 'treated' with inappropriate administration of psychotropic drugs which can lead to complications such as falls, fractures, impaired cognition, and increased risk of death. See Edwin Tan et al, 'Analgesic Use, Pain and Daytime Sedation in People With and Without Dementia in Aged Care Facilities: A Cross-Sectional, Multisite, Epidemiological Study Protocol' (2014) 4(6) *BMJ Open.*

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

The Commission proposed that the *Aged Care Act* be amended to include the regulation of restrictive practices in aged care and provide that restrictive practices only be used:

- When necessary to avert physical harm;
- To the extent necessary to prevent harm occurring;
- With the approval of an independent decision-maker; and
- In accordance with the behaviour management plan of the person to whom the restrictive practice is being applied.[16]

This paper aims to contribute to contemporary discussion about the regulation of restrictive practices in Australian residential aged care settings by exploring the existing laws, policies and practices in Australia and other international jurisdictions. It identifies the legislation (including regulations and standards), case law, and other mechanisms (such as guidelines and safeguards) that comprise the regulatory frameworks that determine the use of restrictive practices.

Australian legal framework

There is no specific legislation governing restrictive practices in residential aged care in Australia. Consequently, there is no legal basis for using restrictive practices without a legal justification or defence. Further, there are very few cases in Australia where civil or criminal law has been used to challenge the use of restrictive practices. An example of one such case was *Skyllas v Retirement Care Australia (Preston) Pty Ltd*.[17]

> ***Skyllas v Retirement Care Australia (Preston) Pty Ltd*** After the son of a Victorian residential aged care resident submitted an affidavit evidencing his belief of his mother's unlawful detainment, the court invoked the writ of habeas corpus (the power of a court to review the lawfulness of an arrest or detainment[18]) and found it unlawful for a residential aged care facility to detain a resident against their will, regardless of their physical health. No further action was taken as the Public Advocate was appointed as the resident's legal guardian for accommodation matters.

This case highlighted that the detention of aged care residents can be considered to be unlawful if carried out without their consent, their attorney or guardian's approval (when allowed by law), or otherwise without legal authority or excuse.

[16] Ibid.
[17] *Skyllas v Retirement Care Australia (Preston) Pty Ltd* [2006] VSC 409.
[18] LexisNexis, *Halsbury's Laws of Australia,* vol 9 (at 20th October 2016) 80 Civil and Political Rights, 2 Civil Rights' [80–1080].

Commonwealth legislation

The *Aged Care Act* is the primary piece of legislation governing aged care services in Australia. There are no provisions in this legislation that address or regulate the use of restrictive practices.

Under section 96-1 the Minister for Health can create user rights, principles and standards which are currently reflected in the *Quality of Care Principles 2014* (Cth). These principles outline standards that may be used to protect residents who are vulnerable to restrictive practices, for example, the requirements to manage challenging behaviours effectively;[19] provide a safe living environment;[20] or to respect residents' independence,[21] dignity,[22] choice, and decision-making.[23]

Section 65-1 of the Act further states that if an aged care provider breaches any of its responsibilities under the Act (including its responsibility to act consistently with the care principles[24]), the Secretary of the Department of Health may impose sanctions that include the removal of funding or license to operate. In the case *Saitta Pty Ltd v Secretary, Department of Health and Ageing*[25] the use of restrictive practices were found to be a breach of the care principles.[26]

> ***Saitta Pty Ltd v Secretary, Department of Health and Ageing*** The Administrative Appeals Tribunal upheld the Department of Health and Ageing's imposition of severe sanctions that led to the closure of the Belvedere Park Nursing Home in Melbourne, following an assessment that residents' safety was at severe and immediate risk. The tribunal described an incident where an unattended resident had been restrained to a chair with a lap-belt an hour after it should have been removed. This was considered a breach of the principle for the right to dignity, for residents to be assisted to achieve maximum independence, and for management to actively work in providing a safe and comfortable environment consistent with the residents' needs. However, there was no further discussion of restrictive practices as the matter focussed on many other serious incidents that led to the finding of severe immediate risk, including poor infection control; poor sanitation; inadequate incontinence management etc.

Given the lack of clear precedent and the broad and ambiguous nature of the care principles, the *Aged Care Act* does not currently act as an effective mechanism for reducing or regulating restrictive practices in the aged care sector.

[19] *Quality of Care Principles 2014* (Cth), sch 2 pt 2 item 2.13.
[20] Ibid sch 2 pt 4 item 4.4.
[21] Ibid sch 2 pt 3 item 3.5.
[22] Ibid sch 2 pt 3 item 3.6.
[23] Ibid sch 2 pt 3 item 3.9.
[24] *Aged Care Act 1997 (Cth)* s 56–1(m).
[25] *Saitta Pty Ltd v Secretary, Department of Health and Ageing* (2008) 105 ALD 55.
[26] Ibid at [122]. It is important to note that the application of restrictive practices was not the core matter being determined and the general use of restrictive practices was not explored in detail in the tribunal decision.

State and territory legislation

Disability and mental health legislation

While Queensland's *Disability Services Act 2006* (Qld) and *Mental Health Act 2016* (Qld) contain provisions regulating the use of restrictive practices in those sectors, they do not apply to or regulate the use of restrictive practices in residential aged care facilities. The *Disability Services Act* only applies to Queensland-government-funded disability service providers and while dementia has been characterised by the court in Queensland as a mental illness in the context of the *Mental Health Act*,[27] the Act is only applicable to the involuntary assessment and treatment of persons who have a mental illness[28] and does not regulate residential aged care facilities.

The *Disability Services Act* provides for a comprehensive restrictive practice regulatory framework with safeguards that require that restrictive practices are only used within the framework of positive behaviour support. A positive behaviour support process requires multi-disciplinary assessments of the person who would be subject to the restrictive practices and their care and support needs along with the development of a positive behaviour support plan that identifies the person's challenging behaviours and contains strategies for responding positively to those behaviours. The object of the process is that the use of a restrictive practice is to be the least restrictive option and applied for the shortest period necessary, with a view to reducing the use of restrictive practices over time. Ultimately, the restrictive practice must be formally approved before it can be used.[29]

The inclusion of restrictive practices provisions in the *Disability Services Act*, and the introduction of accompanying initiatives, has resulted in greater transparency around the use of restrictive practices in Queensland's disability sector. The effect of these initiatives has been increased consistency, professionalism and oversight around the support provided to people whose behaviours may result in harm to themselves or others. Anecdotal reports received by our office also suggest that, when supported by well-developed positive behaviour support plans, these initiatives have contributed to a reduction in the use of restrictive practices and improved outcomes for people with disability who exhibit behaviours of concern.

Equivalent legislation in other Australian states and territories either omit restrictive practices entirely;[30] explicitly exclude conditions related to ageing;[31] or only cover specific disability and mental health services.[32]

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[27] *Re HHR* [2012] QMHC 15.
[28] *Mental Health Act 2016* (Qld) s 3; ch 8.
[29] *Disability Services Act 2006* (Qld) pt 6 - provisions relating to positive behaviour support and restrictive practices; *Guardianship and Administration Act 2000* (Qld) ch 5B - provisions relating to restrictive practices.
[30] *Mental Health Act 2007* (NSW); *Disability Inclusion Act 2014* (NSW); *Disability Services Act 1991* (ACT); *Disability Services Act 1993* (WA).
[31] *Disability Act 2006 (Vic)* s 3 (definition of 'disability').
[32] *Disability Services Act 1993* (SA) s 3A; *Disability Services Act 2012* (NT) s 41; *Mental Health and Related Services Act 1998* (NT); *Mental Health Act 2015* (ACT); *Mental Health Act 2014* (WA) pt 14 divs 5-6; *Mental Health Act 2009* (SA) s 7; *Mental Health Act 2014* (Vic) pt 6; *Disability Services Act 2011* (Tas) pt 6; *Mental Health Act 2013* (Tas).

Guardianship legislation

The restrictive practices provisions in the *Guardianship and Administration Act 2000* (Qld) specifically apply to people with intellectual or cognitive disability who are receiving care from a Queensland Government-funded disability service provider under the *Disability Services Act*.[33] These provisions do not apply to residential aged care services.

However, the general principles articulated in the *Guardianship and Administration Act*[34] may have relevance to the application of restrictive practices in Queensland more broadly, including in aged care services. It could be argued that the authorisation for the use of restrictive practices by appointed or informal decision-makers constitutes a breach of the general principles that require respect for people's dignity.[35] However, no penalties apply for the breach of the general principles, as those people not performing a function or exercising a power under the Act are only 'encouraged' to apply these principles as part of the general 'community'.[36]

Criminal law

In Queensland, unlawful deprivation of liberty is a criminal offence,[37] with equivalent laws existing in legislation or common law in other Australian jurisdictions.[38] Additionally, many instances of restrictive practices that involve the application of force would fulfil the elements of assault.[39] Although there may be a justification or excuse for the use of this force, such actions would have to be justified under existing criminal law.[40] The prosecution of aged care providers or workers with criminal offences may act as a deterrent to the use of restrictive practices, however, such an approach is unlikely to generate practical solutions. Criminalising aged care workers would be impractical and counter-productive, particularly considering workforce shortages in the sector.[41] It also seems unreasonable to expect such workers to properly respond to the challenging behaviours that put the aged care resident or others at risk of harm if the workers may be exposed to criminal prosecution.

There is a precedent in the United Kingdom where the operation of the defence of necessity has been expanded to justify offences that have occurred when managing challenging behaviour of people receiving services in the human services sector. Australian courts have not yet been required to consider a prosecution in these circumstances.[42] However, having general

[33] *Guardianship and Administration Act 2000* (Qld) s 80R.
[34] Ibid sch 1.
[35] Ibid sch 1, principles 3, 7.
[36] Ibid s 11(3).
[37] *Criminal Code 1899* (Qld) s 355.
[38] LexisNexis, *Halsbury's Laws of Australia,* vol 9 (at 20th October 2016) 130 Criminal Law, 2 Assault and Related Offemces' [130–1165].
[39] Ibid [130–1000].
[40] See, for example in Queensland, extraordinary emergency, *Criminal Code 1899* (Qld) s 25, or self-defence, *Criminal Code 1899* (Qld) s 271.
[41] Peter Holland, Tse Leng Tham and Fenella Gill, *Findings from the National Survey on Workplace Climate and Well-being*, (September 2016) 16.
[42] *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 and *R v Bournewood Community and Mental Health NHS Trust, ex parte L* [1999] 1 AC 458 as cited in Kim Chandler, Ben White and Lindy Willmott, 'The Doctrine of Necessity and the Detention and Restraint of People with Intellectual Impairment: Is there Any Justification?' (2016) 23(3) *Psychiatry, Psychology and Law* 361, 362.

defences open for carers clearly do not create a framework under which both providers and aged care residents can have proper guidance and support in managing restrictive practices or the behaviours that may warrant it.

Other legislation

Victoria has enacted the *Supported Residential Services (Private Proprietors) Act 2010* (Vic), which provides for specific rights and protections for people living in residential aged care services.[43] However, the statute only covers privately-funded aged care accommodation and support. It does not cover residential aged care services that are government-subsidised, which effectively excludes the majority of aged care services from its operation.[44]

Tort law

The use of some restrictive practices would constitute a tort, in particular assault, battery, or false imprisonment.[45] Bringing actions against aged service providers under tort law may result in compensation for mistreated residents but would not necessarily serve as a preventative measure or raise the standard of care for people subject to restrictive practices. Moreover, common law claims usually require professional legal advice, time, and considerable financial resources, as well as the mental capacity and knowledge to identify and progress a tort claim.[46] These barriers result in tort law being inaccessible and impractical for many aged care residents.

Other sources

The Australian Department of Health has developed voluntary guidelines for minimising restrictive practices in aged care.[47] These guidelines could be used as evidence in claims involving negligence or the withdrawal of accreditation of aged care providers,[48] however, there does not appear to be any legal precedent for this.

[43] *Supported Residential Services (Private Proprietors) Act 2010* (Vic) ss 7-8.
[44] Ibid ss 5-6.
[45] LexisNexis, *Halsbuy's Laws of Australia,* vol 9 (at 20th October 2016) 415 Tort, 2 'Torts Derived From Trespass' [415–345], [415–355], [415–395].
[46] Michael Barnett and Robert Hayes, 'Not seen and not heard: protecting elder human rights in aged care' (2010) 14(2010) *University of Western Sydney Law Review* 45, 72.
[47] Department of Health and Ageing (Commonwealth), *Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care* (2012).
[48] Victor Harcourt, 'Physical restraints in residential aged care' (2001) 75(10) *Law Institute Journal* 72, 74.

International legal frameworks

New Zealand

Health and Disability Services (Safety) Act 2001

The *Health and Disability Services (Safety) Act 2001* (NZ) defines residential aged care facilities (referred to as 'rest homes') as paid services that are provided for three or more people in premises which are primarily a residence for people who are frail because of their age.[49] The Act requires rest homes to comply with all relevant service standards,[50] which are currently operationalised as the *Health and Disability Services Standards 2008*.[51] Rest homes commit an offence punishable by a fine if they fail to comply with the standards.[52]

Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

The *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards* are mandatory in New Zealand residential aged care facilities and cover most of the forms of restrictive practices used in these facilities.[53] The objective of the standards is to reduce the use of all forms of restraint and to adopt a least restrictive practice approach.[54] Within this framework, the use of medication as chemical restraint is always in breach of the standards.[55]

There are three standards that underpin the overall framework:

1. Restraint minimisation – outlines the requirements that must be met before restraints are used. Services must have restraint minimisation policies and procedures that include a service philosophy; a method of communicating policy; and a method of applying policy in practice.[56] The service must also practice risk assessment and have service delivery plans designed to minimise the need for restraint.[57] Additionally, staff must receive regular training on the use of restraint and other alternatives.[58]
2. Safe restraint practice – provides standards for when restraints are used. Services must have a transparent process for approving restraint use, type, and duration[59] and an

[49] *Health and Disability Services (Safety) Act 2001* (NZ) s 6(2).
[50] Ibid s 9.
[51] Ministry of Health (NZ), *Services Standards* (2016) <http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/services-standards>.
[52] *Health and Disability Services (Safety) Act 2001* (NZ) s 54(1).
[53] Ministry of Health (NZ), above n 51.
[54] Standards New Zealand, *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (NZ)* 8134.2:2008 (2008) 5.
[55] Ibid 8134.2:2008 (2008) 8134.2.1, 5.
[56] Ibid Standard 1.1.
[57] Ibid Standard 1.2.
[58] Ibid Standard 1.5.
[59] Ibid Standard 2.1.

assessment process that is undertaken before restraining a person.[60] Restraints are only to be used by qualified health workers as a last resort and, once in place, restraints must be monitored, evaluated, and documented.[61] Each of the standards has more detailed subsections and is often accompanied by practice guidelines.

3. Seclusion – outlines the standards regarding the use of seclusion, including its use only for safety reasons[62] and for the seclusion to occur only in approved and designated seclusion rooms.[63]

Comments

The New Zealand Health and Disability Standards provide clear, thorough and accessible best practice guidelines that are prescribed by legislation. They are accompanied by a deterrent for non-compliance in the form of a substantial fine. Additionally, there is monitoring through audits, with audit reports publicly available online.[64]

The auditing system has been criticised for permitting aged care services to appoint an auditor themselves. Further, the auditing criteria have been described as broad and not specific to aged care, resulting in inconsistent standards of care across residential aged care providers.[65]

There is an apparent mismatch between standards and ensuring that the aged care sector is adequately resourced to implement them. New Zealand has no specified staffing level requirements or workload limit, and work in aged care is generally poorly remunerated and under-valued, with the result being an under-qualified, over-worked, or dispassionate workforce.[66] The aged care system has attracted criticism over its somewhat bureaucratic focus on meeting minimum standards rather than achieving resident satisfaction.[67]

United Kingdom

Care Standards Act 2000 and *Care Home Regulations 2001*

The *Care Standards Act 2000* (UK) confers power on the Secretary of State to make regulations that establish standards for residential care homes (including aged care services[68]) in England, Northern Ireland and Wales, with each of those jurisdictions having the same provisions.[69] The *Care Home Regulations 2001*[70] and its equivalent in other United Kingdom jurisdictions

[60] Ibid Standard 2.2.
[61] Ibid Standard 2.3 – 2.5.
[62] Ibid Standard 3.1.
[63] Ibid Standard 3.2.
[64] Ministry of Health (NZ), *Rest Homes* New Zealand Government<http://www.health.govt.nz/your-health/certified-providers/aged-care>.
[65] Human Rights Commission (New Zealand), *He Ara Tika: A pathway forward* (June 2016), 42.
[66] Blake Henley, 'Doing aged residential care better – the view from the trenches' (2015) 21 *The New Zealand Medical Student Journal* 7, 8.
[67] Human Rights Commission (New Zealand), above n 65.
[68] *Care Standards Act 2000* (UK) c 14, ss 3, 22.
[69] *Care Home (Wales) Regulations 2002*, SI 2002/344; *The Residential Care Homes Regulations (Northern Ireland) 2005* SR 2005/161.
[70] *Care Home Regulations 2001* (UK) SI 2001/3965.

provide that restraint can only be used when it is the only practicable method of ensuring the welfare of the resident or another resident, and there are exceptional circumstances.[71] The use of restraints must also be documented.[72]

Appendix A presents additional detail in relation to the rules and regulations around the use of restraint in each jurisdiction of the United Kingdom.

Regulation of Care (Scotland) Act 2001

Scotland has a slightly different framework to the rest of the United Kingdom as the *Regulation of Care (Scotland) Act 2001* enables Scottish Ministers to create the *National Care Standards: Care Homes for Older People.*[73] The standards have two provisions related to restrictive practices, which in turn prescribe further requirements for restraint use.[74]

Aged care services must have a written restraints policy, trained and supported staff and support for aged care residents after the use of restraint. Any use of restraint must be documented in residents' personal plans and records of any incidents involving restraint must be kept.[75] Additionally, restraint is only permitted when it is strictly necessary and all other forms of intervention have been unsuccessful.[76]

Deprivation of Liberty Safeguards

In the United Kingdom, personal liberty is protected by Article 5 of the *European Convention of Human Rights*.[77] This article protects people's right to liberty and requires that any deprivation of liberty be carried out in accordance with law. Thus, residents cannot be detained in residential aged care facilities unless such actions are undertaken in accordance with the Deprivation of Liberty Safeguards (DOLS) under the *Mental Capacity Act 2005* (UK).[78] The DOLS contain a number of 'qualifying requirements', including that the resident must have a mental disorder; must lack the capacity to decide on their living arrangements and treatment; and must be detained only when it is in their best interests.[79]

The cases outlined below, demonstrate that this safeguard is being applied to the care of many aged care residents with dementia or similar conditions in the United Kingdom. These cases also indicate that some judges are unwilling to place people in nursing homes where there is a possibility of home care, regardless of whether the DOLS apply.

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[71] Ibid s 13(7).
[72] Ibid s 13(8).
[73] *Regulation of Care (Scotland) Act 2001* s 5(1); Scottish Government, 'National Care Standards: Care Homes For Older People' No 2007.
[74] Scottish Government, *National Care Standards: Care Homes For Older People* (2007).
[75] Ibid Standard 5.11.
[76] Ibid Standard 9.8.
[77] *Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953), as amended by Protocol No. 16 to the Convention on the Protection of Human Rights and Fundamental Freedoms, opened for signature 2 September 2013, CETS 214 (not yet in force).
[78] *Mental Capacity Act 2005* (UK) sch A1.
[79] Ibid pt 3.

***CC v KK & STCC*[80]**

An elderly woman with dementia was found to have capacity despite two psychiatrists' assessments and carers' opinions to the contrary. The woman's overnight care program was not considered to be a deprivation of liberty as the woman was only required to stay in the residential aged care facility overnight for the purpose of providing a significant level of care and was taken home every day.

***A London Local Authority v JH* (by her litigation friend, the Official Solicitor, MH)[81]**

A woman with dementia satisfied the mental health component of the DOLS. The court found that, while residential aged care would not constitute a deprivation of liberty, a less intrusive method of at-home care would be more appropriate. The court ordered that the woman return home with an appropriate care package provided by the local authority.

***Westminster City Council v Manuela Sykes (by her RPR and litigation friend, RS)* [82]**

A judge found that an elderly woman with severe dementia had sufficient capacity to decide on her living arrangements and comprehend the associated risks. The judge stated that the woman's safety was one part of the consideration, however it was not the overriding consideration.

Comments

A report commissioned by the Department of Health found that a lack of a national data collection regarding residential aged care facilities made it difficult to determine how well the United Kingdom's care home laws were functioning.[83] The report highlighted that some studies found an increase in the use of restraints after the DOLS was introduced (possibly as a result of increased scrutiny and reporting).[84] Much like other jurisdictions, the legislation has been criticised for focussing on minimum standards and preventing abuse rather than aiming higher and actively promoting rights.[85] Additionally, it has been argued that policy in this area has been influenced by the commercial aged care sector rather than by consumer needs.[86]

Canada

Canada has no federal legislation governing restrictive practices in residential aged care services. There are, however, provincial legislation and regulations in Alberta,[87] British

[80] *CC v KK & STCC* [2012] EWHC 2136 (COP).
[81] *A London Local Authority v JH (by her litigation friend, the Official Solicitor) and MH* [2011] EWHC 2420 (COP)
[82] *Westminster City Council v Manuela Sykes (by her RPR and litigation friend, RS)* [2014] EWCOP B9, [2014] EWHC B9 (COP)
[83] Policy Innovation Research Unit, *Indepdendent assessment of improvements in dementia care and support since 2009* (2014)
[84] Ibid 43.
[85] Geraldine Boyle, 'The Mental Capacity Act 2005 Deprivation of Liberty Safeguards and people with dementia: the implications for social care regulation' (2009) 17(4) *Health and Social Care in the Community* 415, 416.
[86] Geraldine Boyle, 'Facilitating choice and control for older people in long-term care' (2004) 12(3) *Health and Social Care in the Community* 212, 213.
[87] *Nursing Homes General Regulation,* Alta Reg 232/1985; Alberta Health, *Continuing Care Health Service Standards* (2016).

Columbia,[88] Manitoba,[89] New Brunswick,[90] Newfoundland/Labrador,[91] Ontario,[92] Quebec[93] and Saskatchewan.[94] These provide that restraint is only to be used where there is a risk of harm to a person, and/or where all other methods of reducing the risk of harm have been tried. Appendix B presents additional detail in relation to the legislation governing the use of restrictive practices in Canadian provinces.

Most provinces have additional requirements in relation to the use of restrictive practices that include: orders from a medical professional; use of the least restrictive method possible; supervision and regular review of the restraints; and documentation about the restraints and their use. Ontario, Alberta and Saskatchewan also require that the aged care resident or their legal decision-maker are consulted about the use of restrictive practices, including the type of restraint being proposed, the manner in which it will be used and the care of the resident while being restrained.[95]

Comments

While the majority of Canada's provinces have legislation discouraging the use of restrictive practices in residential aged care, there appears to be a degree of disconnect between the legal framework and professional practice. In a 2009 study that compared the prevalence of physical restraints in residential aged care services across five countries, Canada evidenced the highest incidents of restraint.[96] The study also noted that while there was a high prevalence of physical restraint in Canada, there had been a reduction in the use of physical restraint since the mid-1990s.[97]

It has been suggested that the positive developments in terms of law and guidelines in Canadian provinces will not achieve improvements in the use of restrictive practices in the aged care system without attending to staff training, organisational structures and directing the implementation of the law and related guidelines.[98] This proposition is supported by a study of residential aged care services in Alberta, which found that changing organisational structure so that staff were provided with positive role-models and a supportive environment

[88] *Community Care and Assisted Living Act*, SBC 2002, c 75; *Residential Care Regulation* BC Reg 96/2009.
[89] *The Health Services Insurance Act,* CCSM c H35; *Personal Care Homes Standards Regulation* Man Reg 49/2009.
[90] *Nursing Homes Act,* SNB 1982, c N-11;*General Regulation 85-187* NB Reg 187-85.
[91] *Personal Care Home Regulations* NLR 15/01; Newfoundland and Labrador Department of Health and Community Services, *Long-Term Care Facilities in Newfoundland and Labrador: Operational Standards* (2005)
[92] *Retirement Homes Act,* SO 2010, c 11; *Long Term Care Homes Act,* SO 2007, c 8.
[93] *An Act Respecting Health Services and Social Services,* CQLR c S-4.2.
[94] *Personal Care Homes Act*, SS 1989-90, c P-6.01; *Personal Care Homes Regulations,* 1996 , RRS, c P-6.01, Reg 2.
[95] *Personal Care Homes Regulations* RRS P6.01, Reg 2*,* s22.1(c); Alberta Health, Continuing Care Health Service Standards (2016), r 16.1(c); *Long Term Care Homes Act,* SO 2007, c 8 s 31(2).
[96] Zhanlian Feng et al, 'Use of physical restraints and antipsychotic medications in nursing homes: a cross-national study' (2009) 24 *International Journal of Geriatric Psychiatry* 1110, 1111,1116; The results of the study found that the prevalence of physical restraint averaged 31% in Canada, 28% in Finland, 20% in Hong Kong, 9% in the United States of America and 6% in Switzerland.
[97] Zhanlian Feng et al, 'Use of physical restraints and antipsychotic medications in nursing homes: a cross-national study' (2009) 24 *International Journal of Geriatric Psychiatry* 1110, 1116.
[98] Dean Fixsen et al, 'When evidence is not enough: The challenge of implementing fall prevention strategies' (2011) 42 *Journal of Safety Research* 419, 421.

led to a decrease in restraint usage.[99] Other studies have suggested that positive attitudes to least-restraint policies can only take effect with adequate staffing[100] and qualified staff.[101]

United States of America

The most significant piece of legislation regarding residential aged care in the United States of America is the *Omnibus Budget Reconciliation Act of 1987*, which contained the *Nursing Home Quality Reform Act.* This Act provides for nursing home standards; survey and certification standards for the purpose of assessing compliance; and sanctions and enforcement procedures to address non-compliance in nursing homes.[102] The Act also contains the Nursing Home Bill of Rights that requires nursing home residents to be free from "physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms".[103] Physical or chemical restraints can be used to preserve the safety of the resident or others in an emergency, but they must otherwise be authorised by a written prescription with details of the circumstances and reasoning for restraint.[104] In addition to federal law, almost every American state has its own standards regulating restraint in nursing homes.[105]

Comments

There is a general consensus in the literature that the use of restraint in American nursing homes has decreased since the introduction of legislation.[106] However, there is a view that further improvement could be achieved, particularly in nursing homes receiving low Medicaid[107] funding at a state level.[108]

The aged care system in the United States of America features a tension where nursing home staff can be sued for deprivation of liberty for restraining a resident unnecessarily, however they may also be sued for negligence if they fail to restrain a patient who comes to harm.[109] This situation may be difficult to both resolve and defend given that the Supreme Court of Wisconsin found in *Cramer v Theda Clarke Memorial Hospital* that "[one] does not need to be

[99] Doris L. Milke et al, 'A Longitudinal Evaluation of Restraint Reduction within a Multi-site, Multi-model Canadian Continuing Care Organization' (2008) 27(1) *Canadian Journal on Aging* 35, 41.
[100] Jaime Williams et al, 'A qualitative investigation of injurious falls in longterm care: perspectives of staff members' (2011) 33(5) *Disability and Rehabilitation* 423, 427.
[101] Robert Weech-Maldonaldo et al, 'Nurse Staffing Patterns and Quality of Care in Nursing Homes' (2004) 29(2) *Health Care Management Review* 107, 111.
[102] Evan M. Meyers, 'Physical Restraints in Nursing Homes: An Analysis of Quality of Care and Legal Liability' (2002) 10(1) *The Elder Law Journal* 217, 224.
[103] Julie A. Braun and Lawrence A. Frolik, 'Legal Aspects of Chemical Restraint Use in Nursing Homes' (2000) 2(2) *Marquette Elder's Advisor* 21, 24.
[104] Kathy Kleen, 'Restraint regulation: The tie that binds' (2004) 35(11) *Nursing Management* 36, 37.
[105] See 42 U.S.C. § 1395i-3 (applying to any facility that accepts Medicare reimbursement); 42 U.S.C. § 1396r (applying to any facility that accepts Medicaid reimbursement); Julie A. Braun and Lawrence A. Frolik, 'Legal Aspects of Chemical Restraint Use in Nursing Homes' (2000) 2(2) *Marquette Elder's Advisor* 21, 25.
[106] Meyers, above n 102, 220; Zhanlian Feng et al, above n 96, 1116; Fixsen et al, above n 98, 420; Milke et al, above n 99, 46.
[107] The US social health care funding for people on low incomes and other eligibility criteria.
[108] David Grabowski, Joseph J. Angelelli and Vincent Mor, 'Medicaid Payment And Risk-Adjusted Nursing Home Quality Measures' (2004) 23(5) *Health Affairs* 1, 3.
[109] Kathy Kleen, above n 104.

an expert to be able to determine whether a person should be in or out of restraints".[110] This judgment assumes that a decision to undertake a restrictive practice is straightforward, logical, and requires no clinical expertise. This position contrasts with the view that the appropriate use of restrictive practices is not an intuitive response but a skill that must be learned through training.[111]

European nations

As many European nations do not publish legislation in English, the following information is primarily based on Alzheimer Europe's *Dementia in Europe Yearbook 2011,*[112] which in that year outlined the restrictive practice laws for 30 European countries. This yearbook focused on people with dementia and also provided information on restrictive practice laws that are applicable to nursing homes.

Most of the countries reviewed in the yearbook had no specific laws regarding the use of restrictive practices, however most had mental health legislation, established constitutional rights to freedom of movement, and/or established deprivation of liberty offences in criminal law.

Some countries had developed different approaches. For example, restraints in Croatian nursing homes were governed by family violence legislation under the classification of elder abuse.[113] In Germany, strict staffing standards were established to reduce the use of restraint.[114]

Appendix C contains a table summarising whether each European nation has specific legislation relevant to aged care and involuntary treatments.

Comments

It is difficult to evaluate the effectiveness of these frameworks without specific knowledge of the legislation or legal systems that operate in each European nation, however individual studies provide some insights. The German framework has been found to feature some shortcomings, for example, one study found that over 30 per cent of residential aged care residents had been physically restrained for more than 20 days per month, despite there being requirements for minimal staffing levels.[115] Another study found that 28% of aged care

[110] *Cramer v. Theda Clark Memorial Hospital* 45 Wis.2d 147 (1969).
[111] In Australia, staff training and education is considered to be a key element in reducing the use of restraints across sectors. See Department of Social Services, *National Framework for Reducing and eliminating the Use of Restrictive Practices in the Disability Service Sector* (2013) <https://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/national-framework-for-reducing-and-eliminating-the-use-of-restrictive-practices-in-the-disability-service-sector> 12.
[112] Alzheimer Europe, *Dementia in Europe Yearbook 2011* (2011).
[113] Ibid 25.
[114] Charlene Harrington et al, 'Nursing Home Staffing Standards and Staffing Levels in Six Countries' (2012) 44(1) *Journal of Nursing Scholarship* 88, 93.
[115] Gabriele Meyer et al, 'Restraint use among nursing home residents: cross-sectional study and prospective cohort study' (2008) 18 *Journal of Clinical Nursing* 981, 987.

residents in Finland and 6% of aged care residents in Switzerland experienced physical restraint at some stage, which was lower than the rate at which aged care residents were subject to restraint in Canada (31%).[116] As there is little, if any, legislation specifically dealing with the issue of restrictive practices in European countries, there are few legal safeguards in place to protect residents in aged care.

Key findings

The key legislation governing the activities of federally-funded aged care services in Australia — the *Aged Care Act 1997* (Cth) — does not prohibit, legislate for, or regulate the use of restrictive practices to manage the challenging behaviours of some aged care residents. States and Territories have legislation regulating the use of restrictive practices in human services sectors such as disability and mental health, but these regimes are not consistent across the country.

Queensland has a comprehensive regulatory framework for the use of restrictive practices by state government-funded disability service providers, under the *Disability Services Act 2006,* that should be considered as a potential model for adoption by the aged care sector in Australia. The adoption of a properly regulated regime has resulted in greater transparency around the use of restrictive practices in Queensland's disability sector and increased consistency, professionalism and oversight of these practices.

The legal and service quality frameworks for restrictive practices in aged care in international jurisdictions that have been reviewed for this paper provide a range of options which could be considered for adoption in Australia. Some of the key features of these systems include:

- the implementation of legislation, standards, regulations and/or safeguards that outline best-practice, evidence-based requirements regarding the use of restrictive practices;
- establishing principles that underpin the framework – for example, that restrictive practices may only be used in instances where a person is at risk and when all other less restrictive measures have been attempted;
- prohibiting the use of medication as a form of chemical restraint;
- a rigorous system of auditing for restrictive practices;
- substantial penalties for non-compliance with aged care service and restrictive practice standards;
- ensuring that state and national restrictive practice frameworks are congruent; and
- encouraging the judiciary to promote the freedoms and independence of older people.

[116] Zhanlian Feng et al, above n 96.

There are also gaps in and criticisms of the existing international restrictive practice frameworks. They include:

- legislation may focus more on meeting minimum standards than upholding older people's human rights;
- an overly bureaucratic approach to meeting minimum standards rather than focusing on customer satisfaction;
- policy frameworks may be overly influenced by the commercial, for-profit aged care sector;
- failure to establish and implement minimum resourcing requirements (e.g. workload limits and minimum staffing levels) to support the objectives of legislation;
- failure to establish functional interconnections between the legislative framework and professional practice;
- auditing criteria is not sufficiently specific to aged care and restrictive practices; and
- the lack of a consistent data collection and reporting strategy regarding the use of restrictive practices.

Conclusion

Australia has been slow to act to regulate the use of restrictive practices to manage the challenging behaviour of people with dementia and mental health issues in residential aged care. The current lack of policy and legislation regulating restrictive practices is out of step with the laws, standards and regulations currently in operation in other comparable Western countries including New Zealand, the United Kingdom, the United States of America and Canada.

It is also apparent, however, that none of the international jurisdictions reviewed in this paper has perfected its approach to the use and regulation of restrictive practices in aged care services. There is considerable work required to ensure that legal frameworks are supported by appropriate resourcing, training (such as professional development for workers in aged care) and culture to support an ethical and best-practice approach to care and the use of restrictive practices. Australia has an opportunity to critically review the performance of relevant policies and legislation in international jurisdictions, and the findings of academic studies in this area, and enact effective, rights- and evidence-based policy and legislation for the regulation of restrictive practices in the aged care sector.

While the regulation of restrictive practices in residential aged care services will advance the protection of the legal and human rights of older Australians, regulation alone will not result in reduced or eliminated use of restrictive practices in aged care settings. Issues relating to the current culture, staffing and operation of services in the sector must also be addressed if we are to see real gains in improving the quality of life and safeguarding the rights of older people living in residential aged care settings in Australia.

Appendix A – Restrictive practice frameworks in the United Kingdom

Jurisdiction	Legislation
England	The *Care Standards Act 2000* (UK) gives power to the ***Care Home Regulations 2001*** **(UK) SI 2001/3965.** ***Care Home Regulations 2001*****: Section 13(7)** states restraints are not to be used unless they are the only practicable method of ensuring the welfare of the resident or another resident and there are exceptional circumstances. **Section 13(8)** requires any incident of restraint to be documented.
Northern Ireland	The *Care Standards Act 2000* (UK) is applied as the ***Residential Care Homes Regulations (Northern Ireland) 2005*** **(SR 2005/161)**. ***Residential Care Homes Regulations (Northern Ireland) 2005:*** **Section 14(5)** states restraints are not to be used unless they are the only practicable method of ensuring the welfare of the resident or another resident and there are exceptional circumstances. **Section 14(6)** requires any incident of restraint to be documented.
Wales	The *Care Standards Act 2000* (UK) is applied as the ***Care Home (Wales) Regulations 2002*** **(SI 2002/344**). ***Care Home (Wales) Regulations 2002:*** **Section 13(7)** states restraints are not to be used unless they are the only practicable method of ensuring the welfare of the resident or another resident and there are exceptional circumstances. **Section 13(8)** requires any incident of restraint to be documented.
Scotland	The *Regulation of Care (Scotland) Act 2001* applies in Scotland and allows Scottish ministers to publish care standards. These are the ***National Care Standards: Care Homes for Older People*****:** The **Glossary** part defines restraint as a control to prevent a person from harming themselves or other people by the use of physical means; mechanical means; environmental means; or medication. **Standard 5.11** outlines the requirements for restraint use as: being in the resident's care plan, being carried out by trained and supported staff, being documented, and being carried out as per a written restraints policy. This section also states that a resident who has been restrained will be supported after the incident. **Standard 9.8** requires all other forms of intervention to be exhausted before restraints are used.

Appendix B – Restrictive practice frameworks in Canadian provinces

Province	Legislation
Alberta	***Continuing Care Health Service Standards*** **(Alberta Health 2016)***:* The **definitions** part defines restraints as including pharmacological, environmental, mechanical or physical measures used with the intention of protecting a resident from self-harm or preventing harm to another person. **Section 16** outlines an extensive process for restraint use**. Section 16.1** requires a number of events and actions to occur for restraint to be used, including: the resident poses immediate risk to themselves or others; supportive interventions have been tried and failed or assessed as inappropriate; the least restrictive measure is chosen; the resident's legal representative is informed; there is a policy for frequency and method of monitoring restrained residents; and (if a chemical restraint) a plan for gradual dose reduction is in place. Additionally, **section16.2** requires that an interdisciplinary team must regularly review restraints and **Section 16.3** mandates detailed documentation of the restraints and circumstances leading to their use.
British Colombia	***Residential Care Regulation*** **(B.C. Reg 96/2009)**: **Section 1** defines restraints as including chemical, electronic, mechanical, physical or other means of controlling or restricting freedom of movement. **Section 73 (1)** provides restraints are only to be used if they are necessary to prevent harm; minimal in type and duration; and used with respect to the resident's safety and dignity. **Section 73 (2)** states that restraint use must be a last resort; carried out by trained staff; and documented, whilst **section 73 (3)** requires that after the restraint, documented advice and information must be provided to the resident, employees involved in the restraint, and any eyewitness to the restraint. **Section 74** provides the circumstances when restraint is allowed (in an emergency or where there is valid consent) and is prohibited (for the purposes of convenience or punishment). **Section 75** outlines the need for and process of regularly reviewing restraints in use.
Manitoba	***Personal Care Homes Standards Regulation*** **(Man Reg 49/2009)**: **Section 1** defines restraints as "any restriction of the voluntary movement of a resident, to ensure the safety of the resident or others." **Section 16** requires homes to have a written policy on restraints. **Section 17** states that restraint is only to be used where there is a risk of serious harm; positive intervention methods have been tried; and an order has been made by a physician, a registered nurse, a licensed practical nurse or a registered psychiatric nurse. **Section 18** covers the requirements for maximum safety and comfort in restraints, documentation, regular review, and immediate discontinuation as soon as it is appropriate.
New Brunswick	***General Regulation 85-187*** **(NB Reg 187-85)**: **Section 20 (1)** mandates restraints are only to be used to protect the resident or others from injury, with a written order from a physician, nurse or nurse practitioner who has attended the resident. Additionally, **section 20 (3)** requires that restraints must not cause physical injury; be as comfortable as possible; be reviewed by a nurse every two hours; and be able to be released immediately by staff.

Province	Legislation
Newfoundland/Labrador	There are informal operational standards these provinces that are published by the government as minimum standards of care. ***Long-Term Care Facilities in Newfoundland and Labrador: Operational Standards*** **(Newfoundland and Labrador Department of Health and Community Services 2005)**: **Section 8, Standard 1** states restraints are only to be used as a last resort when there is a threat of harm to the resident or others, after all other methods of intervention have been exhausted.
Ontario	Ontario has two piece of relevant legislation; the ***Retirement Homes Act*** (covering low care residential complexes) and the ***Long Term Care Homes Act*** (covering high care residential complexes). ***Retirement Homes Act*****, SO 2010, c 11**: Unless used in accordance with the Act, restraints and confinement are generally prohibited by **section 68.** Under **section 71 (1),** caregivers have a common law duty to restrain people when there is an immediate risk of bodily harm to that person or others. There are also proposed rules regarding the process to use restraints in **s70**, however, they are not yet in effect. ***Long Term Care Homes Act,*** **SO 2007, c 8**: Under **section 3 (1),** residents have the right not to be restrained except in accordance with the Act. This is expanded in **section 30 (1)**, which states residents are not to be restrained for convenience or punishment, or by physical, chemical, or environmental restraints unless in accordance with the Act. **Section 31** allows residents to be restrained if it is already included in their care plan; outlines the requirements for including potential restrain in a plan; and requires that restraints be minimised and as safe as possible. **Section 34** mandates all restraint incidents must be documented.
Quebec	***An Act Respecting Health Services and Social Services,*** **CQLR c S-4.2**: **Section 118.1** provides that force, isolation, mechanical means or chemicals are not to be used except where the resident poses a risk to themselves or others. Measures must only be used in exceptional circumstances and must be appropriate for the person's mental and physical health. Any measures taken must be documented and there must be a written restraints policy to be reviewed annually
Saskatchewan	***Personal Care Homes Regulations*****, 1996, RRS c P-6.01 Reg 2**: **Regulation 2** defines restraints as any device that limits, restricts, confines, or controls, or deprives of freedom of movement. **Regulation 22.1** mandates restraint is only to be used to assist with healing or daily living and must be by written order from a physician. **Regulations 22** requires nursing homes to use the least restrictive restraint possible for the least possible length of time.

Appendix C – Restrictive practice frameworks in the European nations[1]

Country	Restrictive practice provisions	Mental health provisions	DOL[2] Provisions	Constitutional rights	Other
Austria	No	Yes	Yes	No	Multi-disciplinary advocates review or challenge restrictive practices
Belgium	No	Yes	No	No	
Bulgaria	No	Yes	No	No	
Croatia	No	No	No	No	Covered by the definition of elder abuse in family violence legislation
Cyprus	No	No	No	No	
Czech Republic	Yes (social and medical services)	Covered by RP laws	No	No	
Denmark	Yes (nursing homes)	No	No	No	
Estonia	Yes (welfare institutions) but does not cover restraints	Yes (including restraints)	Yes	No	
Finland	No	Yes	No	Yes	
France	No	Yes	No	No	
Germany	No	Yes	Yes	Yes	Minimum staffing requirement
Greece	No	No	Yes	No	
Hungary	Yes (any patient of a doctor)	Covered by RP laws	No	No	
Iceland	No	No	Yes	No	
Ireland	No	Yes	No	No	
Italy	Only for medical interventions	No	No	Yes	

[1] Alzheimer Europe, *Dementia in Europe Yearbook 2011* (2011).
[2] Deprivation of liberty

Country	Restrictive practice provisions	Mental health provisions	DOL Provisions	Constitutional rights	Other
Latvia	No	No	Yes	No	
Lithuania	No	Yes	No	No	
Luxembourg	No	Yes	Yes	No	
Malta	No	Yes	Yes	No	
Netherlands	Only in medical settings	Covered by RP laws	No	No	
Norway	No	Yes	Yes	No	
Poland	No	Yes	Yes	No	
Portugal	No	Yes	Yes	No	
Romania	No	No	Yes	No	
Slovakia	No	No	No	No	
Slovenia	No	No	Yes	No	
Sweden	No	No	No	No	Non-compulsory guidelines for Alzheimer's patients and compulsory minimum staffing currently being investigated
Switzerland	No	No	No	No	
Turkey	No	Yes	No	No	
Latvia	No	No	Yes	No	
Lithuania	No	Yes	No	No	

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