The Secretary,
Parliamentary Joint Committee on Human Rights,

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

Dear Secretary,

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

I am writing regarding the response the Parliamentary Joint Committee received to questions it raised with the Department of Health in correspondence dated 28 August 2019. I remain concerned about the rights of residents subject to restraint in residential aged care facilities and the paucity of the proposed principles to regulate such use.

I refer to the information provided on the Committee's website regarding the prospective notice to disallow the amendment and the questions on notice to the Health Portfolio ('Health').

Consent to restraint by the resident/patient
In the response of Health to the Committee, Health, in effect, regards the consent provided to *the doctor or nurse practitioner* as sufficient authorisation of use of the restraint by *the provider*. I query if this is so as a matter of logic, practice or law.

I foresee two scenarios.

1. Where the consent has been given to a doctor or nurse practitioner who is a member of staff of the provider, it would seem the consent would cover both the doctor, nurse and the provider.
2. Where the consent has been given to a doctor or nurse practitioner who is not a member of staff of the provider, it would seem the consent would only cover the doctor or nurse practitioner, not the provider.

In the second (and, I believe, more common) scenario, it is the provider who is at risk of committing an assault or trespass to the person through the implementation of the restraint, not the doctor or nurse practitioner. There is nothing in the principles to guide providers about their reliance on the communication by the doctor or nurse practitioner of the resident's consent.

- Minimally, one would expect the doctor or nurse practitioner to record the resident's giving of the consent in the clinical record and, where the resident is known to have diminished capacity to provide informed consent, how the resident was able to provide that consent.

Office of the Public Advocate
Level 1, 204 Lygon Street, Carlton, Victoria, 3053
DX 210293 Local Call: 1300 309 337
TTY: 1300 305 612 Fax: 1300 787 510
www.publicadvocate.vic.gov.au

- Where the provider is aware that the resident is unable to provide informed consent, there should be guidance that any consent so given and recorded would not be valid and could not be relied upon by the provider to avoid civil or criminal penalties.

Consent to restraint by others

I am advised that there is nothing in the common law that permits a person or representative (however well-meaning and/or familial) to consent on another's behalf to physical or chemical restraint[1].

Victoria has statutes that permit decisions to be made for other persons about restraint. In the civil sphere I am aware of three that could permit the use of restraint –

- The *Guardianship and Administration Act 1986*, which allows for the appointment of a guardian with powers to permit the use of restraint where to do so is in a person's best interests;
- The *Disability Act 2006*, which allows the use of restraint as part of a person's behaviour support plan where this is reported to the Senior Practitioner, and also where the person is subject to a Supervised Treatment Order; and
- The *Mental Health Act 2014*, which allows for the use of restrictive practices on a person receiving mental health services in a designated mental health service.

It might be argued that an attorney for personal matters appointed under an enduring power of attorney may have such authority. However, this is not obvious from the definition of 'personal matter' in Victoria's *Powers of Attorney Act 2014*. Given the seriousness of the use of restraint on a person's legal and human rights, I am advised that the giving up of such authority would usually require explicit wording in legislation[2]. There is no explicit wording in the *Powers of Attorney Act*.

Chemical restraint as medical treatment

The previous point was made on the basis that the use of restraint is not medical treatment (as defined in Victoria's *Medical Treatment Planning and Decisions Act 2016).*

In its answers to your questions, Health sets out the process for a doctor or nurse practitioner prior to prescribing a medication 'for the purposes of managing the behavioural or psychological symptoms of dementia'. It requires -

- A clinical assessment
- Satisfaction that other non-pharmacological methods have been tried and failed
- The resident must be experiencing symptoms likely to be alleviated by the proposed medication.

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[1] Consent may be dispensed with in emergencies or where necessary until proper lawful authority has been obtained.

[2] Under the 'principle of legality', fundamental rights cannot be overridden by general or ambiguous words.

- A clinical judgement
- A review to see whether the treatment is beneficial.

Such an approach may fall within the definition of medical treatment under Victoria's *Medical Treatment Planning and Decisions Act 2016* and so consent could be provided by a person's medical treatment decision maker. Health acknowledged the need for consent in its answers –

> The practitioner would make a clinical judgement about the person's capacity to provide informed consent to the medication and seek informed consent, either from the person, or their representative if they do not have capacity to consent.

The *Medical Treatment Planning and Decisions Act* provides –

> medical treatment means any of the following treatments of a person by a health practitioner for the purposes of diagnosing a physical or mental condition, preventing disease, restoring or replacing bodily function in the face of disease or injury or improving comfort and quality of life—
>
> (a) treatment with physical or surgical therapy;
>
> (b) treatment for mental illness;
>
> (c) treatment with—
>
> (i) prescription pharmaceuticals;
>
> ...

If the chemical restraint is medical treatment, consent could be provided by the resident's medical treatment decision maker.

Where a person does not have a medical treatment decision maker, I am required under that Act to consent to, or refuse, the treatment (that is, the restraint). I do not have such a role of last resort where the treatment is routine, only where the treatment is significant.

Victoria's Department of Health and Human Services published guidance to health professionals as to what constitutes routine and significant treatment[3]. In that guideline, antidepressants and antipsychotics are regarded as significant treatment. I understand that these are the usual medications used as chemical restraint.

The *Medical Treatment Planning and Decisions Act* commenced on 12 March 2018. Since that time my office has received less than 20 applications for me to consent to, or refuse, pharmaceutical treatment for residents in aged care. Given the number of people in residential aged care facilities, the percentage who have impaired decision-making capacity to consent to treatment, the percentage of those who do not have a medical treatment decision-maker, I think it unlikely that the consent process outlined by Health in the answers to the Committee's questions is being adhered to in residential aged care facilities in Victoria.

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[3] https://www2.health.vic.gov.au/about/publications/policiesandguidelines/significant-treatment-clinical-guidelines-for-mtpd-act-2016

If the use of restraint is medical treatment requiring consent under Victorian statute law, I do not see how the Rules as currently conceived, and written, will address what I suspect is an extraordinary degree of non-compliance.

Consultation by Health
I note the composition of the Key Stakeholder Working Group does not include any state or territory body that may be empowered to make decisions for others through guardianship orders. I am grateful for the opportunity for such organisations to present to the Committee and present an alternative perspective on the use of restraint on ???

Whilst it may not be the Committee's role to recommend matters to Health, I think it would be beneficial if the composition of the Key Stakeholder Working Group be expanded to include representation from the Australian Guardianship and Administration Council (AGAC) and at least one dedicated human rights organisation.

The Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment ('Convention')

I note Health's response to your question whether the Minimisation of Restraint Principles engages the Convention.

The following have been drawn to my attention that I think are relevant to the Committee's question.

The Convention Against Torture – General Comment No.2 Implementation of Article 2 by State parties provides –

> 15. The Convention imposes obligations on States parties and not on individuals. States bear international responsibility for the acts and omissions of their officials and others, including agents, private contractors, and others acting in official capacity or acting on behalf of the State, in conjunction with the State, under its direction or control, or otherwise under colour of law. Accordingly, each State party should prohibit, prevent and redress torture and ill-treatment in all contexts of custody or control, for example, in prisons, hospitals, schools, institutions that engage in the care of children, the aged, the mentally ill or disabled, in military service, and other institutions as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm. The Convention does not, however, limit the international responsibility that States or individuals can incur for perpetrating torture and ill-treatment under international customary law and other treaties.
> 18. The Committee has made clear that where State authorities or others acting in official capacity or under colour of law, know or have reasonable grounds to believe

> that acts of torture or ill-treatment are being committed by non-State officials or private actors and they fail to exercise due diligence to prevent, investigate, prosecute and punish such non-State officials or private actors consistently with the Convention, the State bears responsibility and its officials should be considered as authors, complicit or otherwise responsible under the Convention for consenting to or acquiescing in such impermissible acts. Since the failure of the State to exercise due diligence to intervene to stop, sanction and provide remedies to victims of torture facilitates and enables non-State actors to commit acts impermissible under the Convention with impunity, the State's indifference or inaction provides a form of encouragement and/or de facto permission. The Committee has applied this principle to States parties' failure to prevent and protect victims from gender-based violence, such as rape, domestic violence, female genital mutilation, and trafficking.

As underlined by the CAT, the prohibition of torture must be enforced in all types of institutions and States must exercise due diligence to prevent, investigate, prosecute and punish violations by non-State officials or private actors.

The article "Aged care, detention and OPCAT" by Laura Grenfell in the Australian Journal of Human Rights published on 18 August 2019. I enclose a copy of the article.

Yours faithfully,

(Dr) Colleen Pearce
Public Advocate (Victoria)