Australian Government
Australian Aged Care Quality Agency

Introduction

Thank you for taking the opportunity to read and consider the draft guidance material that has been developed to support providers of aged care services to meet the new aged care quality standards. We welcome your feedback.

Once completed please save and send this completed form by email to qualityagencypolicy@aacqa.gov.au

Should you require additional support to complete this form, please contact the Australian Aged Care Quality Agency via email qualityagencypolicy@aacqa.gov.au or via phone on 1800 288 025.

1. What is your email address? *(This information will not be published)*

Email:

2. Are you answering on behalf of an organisation? If so, please provide your organisation's name

◉ Yes, on behalf of an organisation	○ No, not on behalf of an organisation

Organisation name: Melbourne Social Equity Institute

3. Do you give consent for your submission to be published in whole or part?

◉ Yes, I give consent	○ No, I don't give consent

4. Where do you live, or, where does your organisation operate? Please select all that apply

☐ NSW	☑ VIC	☐ QLD	☐ WA	☐ SA	☐ TAS	☐ ACT	☐ NT

5. Do you have any specific suggestions in relation to the draft guidance for Standard 1: Consumer dignity and choice? If so, what are they?

N/A

6. Do you have any specific suggestions in relation to draft guidance for Standard 2: Ongoing assessment and planning with consumers? If so, what are they?

N/A

7. Do you have any specific suggestions in relation to draft guidance for Standard 3: Personal care and clinical care? If so, what are they?

Please see attached Word document.

8. Do you have any specific suggestions in relation to draft guidance for Standard 4: Services and supports for daily living? If so, what are they?

N/A

9. Do you have any specific suggestions in relation to draft guidance for Standard 5: Organisation's service environment? If so, what are they?

N/A

10. Do you have any specific suggestions in relation to draft guidance for Standard 6: Feedback and complaints? If so, what are they?

N/A

11. Do you have any specific suggestions in relation to draft guidance for Standard 7: Human resources? If so, what are they?

N/A

12. Do you have any specific suggestions in relation to draft guidance for Standard 8: Organisational governance? If so, what are they?

Please see the attached Word document.

13. On a scale of 1 to 10 (1 being not clear at all and 10 being very clear) how clear is the guidance material overall?

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☑ 6	☐ 7	☐ 8	☐ 9	☐ 10

What would make it clearer?

Please see section 'Gaps and other issues in the Draft Guidance' in the attached Word document.

More generally, the formatting of the document may cause confusion. For example, it is difficult to distinguish between introductory sentences and lists because bullet-points are used throughout entire sections (eg the list of 8 standards on page 1 of 66; the list on page 62 of 166). Cross-references between sections that are linked, such as the discussion of restrictive practices under Standard 3 and the discussion of physical and chemical restraint under Standard 8, could also be useful for providers to understand how their obligations under each Standard fit together.

14. Are there any gaps in the guidance material? If yes, what else should be included in the guidance material, to help aged care service providers to meet the draft new Aged Care Quality Standards?

Please see section 'Gaps and other issues in the Draft Guidance' in the attached Word document.

15. Do you have any other feedback on the guidance material?

Please see the attached Word document.

Once completed please save and send this completed form by email to qualityagencypolicy@aacqa.gov.au

If you wish to contribute more information than the feedback boxes will allow, please attach a Word document or write to us in the body of your email.

Should you require additional support to complete this form, please contact the Australian Aged Care Quality Agency via email qualityagencypolicy@aacqa.gov.au or via phone on 1800 288 025.

Thank you for participating in the survey.

Melbourne Social Equity Institute

Submission to the Aged Care Quality Agency Online Public Consultation

May 2018

The Melbourne Social Equity Institute welcomes the opportunity to make this submission to the Aged Care Quality Agency's Draft Guidance Online Public Consultation.

About the Melbourne Social Equity Institute

The Melbourne Social Equity Institute at the University of Melbourne supports interdisciplinary research on social equity issues across the full spectrum of social life including health, law, education, housing, work and transport. The Institute brings together researchers from across the University of Melbourne to identify unjust or unfair practices that lead to social inequity and work towards finding ways to ameliorate disadvantage. It facilitates researchers working with government and community organisations and helps with the dissemination and translation of research for public benefit.

Research on regulating the use of physical, chemical and mechanical restraint in health care settings

Researchers supported by the Melbourne Social Equity Institute are currently undertaking an Australian Research Council-funded project which addresses the current lack of a common legal framework for regulating the use of restraint in mental health, disability and aged care sectors. While there is some existing regulation of the use of restraint in these settings, legal frameworks within Australia differ significantly and there is inconsistency between different models in terms of the scope, method and content of regulating restraint. This state of patchwork regulation is unsustainable as it fails to protect the human rights of those subject to restraint. The project is aiming to develop model laws and guidelines to support government policy and law reform aimed at reducing, with a view to eliminating, the use of restraint across Australia: https://socialequity.unimelb.edu.au/projects/regulating-the-restraint-of-people-with-disabilities

Restraint and other restrictive practices in aged care

This submission responds to two sections of the Aged Care Standards Guidance Material[1] ('Draft Guidance'):

[1] Australian Aged Care Quality Agency, *Aged Care Standards Guidance Material* (2018) <https://www.aacqa.gov.au/providers/news-and-resources/aged-care-quality-standards/draft-guidance-consultation/copy_of_DraftStandardsGuidanceFullsuiteStandards18.pdf.pdf>.

- Standard 3 – Personal care and clinical care (particularly Section J 'Minimising restrictive practice');
- Standard 8 – Organisational governance (particularly the guidance relating to Requirement 8.3(i) 'minimising the use of physical and chemical restraint').

The submission focuses on the use of different forms of restraint to control behaviour in aged care, including physical restraint (bodily restriction), mechanical restraint (the use of devices or straps) and chemical restraint (the administration of medication, usually for sedation). Other forms of restraint have also been identified in some contexts, including emotional restraint (where a person feels constrained from openly expressing their views) and environmental restraint (where buildings or rooms are designed to control behaviour).[2]

Restraints are generally considered to be one form of 'restrictive practices', meaning 'interventions that have the effect of restricting the rights or freedom of movement of a person in order to protect them'.[3] Other restrictive practices may include seclusion, where a person is confined to a room or area that they cannot freely leave, and involuntary admission, where a person is admitted to a treatment facility against his or her will or without his or her consent.[4]

While the use of restraint and other restrictive practices is lawful in some circumstances in Australia, the shocking findings of recent inquiries into the Oakden Older Person's Mental Health Service ('Oakden') highlighted the lack of regulation and monitoring of the use of restraint in aged care and mental health facilities. The excessive use of mechanical restraint and a lack of staff training on the regulation, use and reporting of restraint at Oakden were singled out for criticism by the Chief Psychiatrist for South Australia, Dr Aaron Groves,[5] and South Australia's Independent Commissioner Against Corruption, the Hon. Bruce Lander QC.[6] In the Review of National Aged Care Quality Regulatory Processes arising from the Oakden scandal, Ms Kate Carnell and Prof Ron Paterson summarised the dangers of restrictive practices:

> *They are known to risk violating consumers' rights and to deliver poor outcomes in many care settings (not only aged care), and are the subject of significant human rights concerns and*

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2 See Melbourne Social Equity Institute, *Seclusion and Restraint Project* (Research Report, University of Melbourne, 2014) <https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0017/2004722/Seclusion-and-Restraint-report.PDF>.

3 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report No 124 (2014) 243.

4 S P Sashidharan and Benedetto Saraceno, 'Is Psychiatry Becoming More Coercive?' (2017) *BMJ* 357, 357 <https://doi.org/10.1136/bmj.j2904>.; see also *Mental Health Act 2013* (Tas) s 3.

5 Aaron Groves, Del Thomson, Duncan McKellar and Nicholas Procter, *The Oakden Report: The Report of the Oakden Review* (Report, SA Health, Department of Health and Ageing, April 2017) 83, 105, 106, 114 <http://www.sahealth.sa.gov.au/wps/wcm/connect/4ae57e8040d7d0d58d52af3ee9bece4b/Oakden+Report+Final+Email+Version.pdf?MOD=AJPERES&CACHEID=4ae57e8040d7d0d58d52af3ee9bece4b>.

6 Bruce Lander, *Oakden: A Shameful Chapter in South Australia's History* (Report, February 2018) 179, 206-208 <https://service.sa.gov.au/cdn/icac/ICAC_Report_Oakden.pdf>.

calls for law reform nationally. They have been, and continue to be, a concern across aged care.[7]

The authors observed that the current Aged Care Accreditation Standards[8] do not adequately address concerns about the use of restraint in aged care, and argued that '[r]egulation should target the things that are important and the problems that are known'.[9]

The outcomes of the various inquiries into Oakden echoed concerns expressed by consumers, human rights bodies, practitioners, academics and others about the high use of restraint in aged care and other settings around Australia. In 2014 the Australian Law Reform Commission highlighted concerns about the improper use and inadequate regulation of restrictive practices and called upon the Federal Government and the Council of Australian Governments (COAG) to 'develop a national approach to the regulation of restrictive practices in sectors other than disability services, such as aged care and health care'.[10]

In its first periodic review of Australia's compliance with the United Nations Convention on the Rights of Persons with Disabilities, the Committee on the Rights of Persons with Disabilities ('the Committee') criticised Australia's use of 'unregulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraints…in various environments, including schools, mental health facilities and hospitals'.[11] Elsewhere, the Committee has characterised 'the use of forced treatment, seclusion and various methods of restraints' as 'not consistent with the prohibition of torture and other cruel, inhuman or degrading treatment or punishment'.[12]

Gaps and other issues in the Draft Guidance

The use of restraint in aged care facilities is not addressed in Commonwealth legislation, although the Department of Health and Ageing has produced a 'Decision-making toolkit' for 'supporting a restraint-free environment in residential aged care'.[13] However, the Senate Community inquiry into dementia observed in 2014 that the toolkit does not offer incentives to minimise the use of restraint or set out penalties for inappropriate use.[14]

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7 Kate Carnell and Ron Paterson, *Review of National Aged Care Quality Regulatory Processes* (Report, October 2017) 45.

8 Quality of Care Principles, made under section 96-1 of the *Aged Care Act 1997* (Cth) sch 2.

9 Ibid.

10 Australian Law Reform Commission, above n 3, 256.

11 Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Periodic Report of Australia*, 10th sess, UN Doc CRPD/C/AUS/CO/1 (21 October 2013) paras 35-6.

12 CRPD Committee, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities*, 14th sess, September 2015 para 12, <http://www.ohchr.org/Documents/HRBodies/CRPD/GC/GuidelinesArticle14.doc>.

13 Department of Health and Ageing, *Decision-Making Tool: Supporting a Restraint Free Environment in Community Aged Care* (2012) <https://www.dss.gov.au/sites/default/files/documents/09_2014/community_aged_care_internals_fa3-web.pdf>.

14 Senate Community Affairs Committee, Parliament of Australia, *Care and Management of Younger and Older Australians Living with Dementia and Behavioural and Psychiatric Symptoms of Dementia (BPSD)* (2014) para 6.45; see also Carnell and Paterson, above n 7, 26.

The current Aged Care Accreditation Standards[15] do not explicitly address or define 'restrictive practices' or 'restraint'. For as long as these practices continue to be lawful, it is crucial that they are subject to adequate regulation and monitoring.

We welcome the inclusion of specific reference to monitoring, reporting, and minimising the use of restraint in Standard 8 of the Draft Aged Care Quality Standards ('the Draft Standards'). This standard will require aged care organisations ('organisations') to implement 'effective governance supported by organisation wide systems for safety and quality, including systems for: … minimising the use of physical and chemical restraint'.[16]

The Draft Standards do not otherwise refer to restraint or other restrictive practices. Consequently, the Draft Guidance – specifically the sections on Standard 3 and Standard 8 – present a crucial opportunity to provide detailed guidance to organisations about the meaning of restraint, the risks associated with its use, and best practice alternatives.

The Need for Clear Definitions of Different Restrictive Practices

At present, the definitions of 'restrictive practices' and 'restraint' in the Draft Guidance are vague and unclear, and inconsistent terminology is used. The terms 'restrictive practices' (p. 47, 62), 'physical chemical [sic] or mechanical restraint' (p. 63) and 'all forms of restraint (physical, chemical, environmental, psychological and emotional)' (p. 160) appear, but are not defined, and the reason for using different terms at different points is unclear and potentially confusing for organisations.

This inconsistency creates a second issue, namely, that the Draft Standards and Draft Guidance risk causing confusion over which specific restrictive practices must be minimised, monitored, and evaluated. For example, Standard 8.3 (and the associated guidance) only refers to 'physical and chemical restraint', whereas the guidance on Standard 3 mention physical, chemical and mechanical restraint. It appears that Standard 8.3 uses an alternative definition of 'physical restraint' that includes both the use of bodily or physical force and the use of mechanical devices such as belts and bedrails.[17] However, without clarification, organisations may form the impression that they do not need to concern themselves with minimising the use of mechanical restraint.

The 'Reflective questions' in Draft Guidance Standard 3 Section J (pp. 62-3) indicate that the term 'restrictive practices' is intended to refer at least to physical, chemical and mechanical restraint. In our view, organisations should be encouraged to minimise the use of *all* forms of restrictive

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15 Above, n 8.

16 Australian Government, Department of Health, *Draft Aged Care Quality Standards* (2018) <https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/01_2018/draft_aged_care_quality_standards_-_word_version.pdf>.

17 This is the definition of 'physical restraint' used, for example, in New South Wales's 'Behaviour Support Policy', which addresses the use of restraint on persons with intellectual disabilities: NSW Department of Family and Community Services, *Behaviour Support Policy (*NSW Government, 2012) 14 <https://www.adhc.nsw.gov.au/__data/assets/file/0007/228364/Behaviour-Support-Policy.pdf>.

practice, including seclusion and the different forms of restraint. To achieve this, the Draft Guidance could be amended as follows:

1. Amend the 'Supporting strategies' section of the Draft Guidance Standard 3 Section J (p. 62) to identify 'all forms of restraint (physical, chemical, environmental, psychological and emotional)', and seclusion, as key forms of restrictive practices that are subject to the standards.
2. Amend the introduction to Draft Guidance Standard 3 Section J (p. 62) and Draft Guidance Standard 8 'Purpose and scope of the standard' (p. 146) to include at least brief definitions of each of these forms of restraint as well as seclusion.[18]

The Need to Explain Why Restrictive Practices Should be Minimised

Some references to restraint or restrictive practices in the Draft Guidance do not clearly state the rationale for minimising, and ideally eliminating, their use. For example, restrictive practices are defined as 'potentially harmful non-therapeutic interventions' in several places in relation to Standard 3 (pp. 47, 62) with no further discussion of these potential harms. We recommend the inclusion of clearer introductory statements about organisations' obligations to minimise, and ideally eliminate, this use. The Explanatory Notes to the National Safety and Quality Health Services Standards (NSQHS Standards) may offer an example of a stronger statement. They include the following paragraph about 'Restrictive practices':

> Minimising and, where possible, eliminating the use of restrictive practices (including restraint and seclusion) are key parts of national mental health policy. Minimising the use of restraint in other healthcare settings besides mental health has also been identified as a clinical priority. Identifying risks relating to unpredictable behaviour early and using tailored response strategies can reduce the use of restrictive practices. Restrictive practices must only be implemented by members of the workforce who have been trained in their safe use. The health service organisation needs processes to benchmark and review the use of restrictive practices.[19]

Similar statements adapted to the aged care context could:

- replace the definition of 'restrictive practices' in Draft Guidance Standard 3 Section A (p. 47); and
- be added to Draft Guidance Standard 8 'Purpose and scope of the standard' (p. 146).

We also recommend that cross-references to Standard 8 and the guidance on Standard 8 be added to the guidance on Standard 3 (and vice versa). This would clarify how the two standards and associated guidance fit together. For example, it would be useful to explain how the 'Supporting strategies' proposed in relation to minimising restrictive practices under Standard 3

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[18] See Melbourne Social Equity Institute, above n 2.

[19] Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (2nd ed, 2017) 40 <https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf>.

(p. 62) are intended to interact with the 'Supporting strategies' proposed in relation to developing policies to govern, monitor and minimise physical and chemical restraint under Standard 8 (p. 160).

We hope this submission will assist in the next iteration of the Guidance and are happy to provide further information if necessary.

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31st May, 2018