8. Restrictive Practices

Contents

Summary

8.1 The term 'restrictive practices' refers to the use of interventions that have the effect of restricting the rights or freedom of movement of a person in order to protect them. Examples include lap belts, hand mitts, removing mobility aids such as walking frames and sedation of a person to control their behaviour.[1] Serious concerns have been expressed about inappropriate and under-regulated use of restrictive practices in a range of settings in Australia.

8.2 Current regulation of restrictive practices occurs mainly at a state and territory level. However, the Commonwealth, state and territory disability ministers endorsed the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (National Framework) in March 2014 to forge a consistent national approach.[2]

8.3 The National Framework is intended to reduce the use of restrictive practices, including by informing the development of the National Disability Insurance Scheme quality assurance and safeguards system (NDIS system).[3] In developing the NDIS system, the ALRC recommends that the Australian Government and the Council of

1 Department of Health, *Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care* <www.health.gov.au>; Department of Health, *Decision-Making Tool: Supporting a Restraint Free Environment in Community Aged Care* <www.health.gov.au>.

2 Australian Government, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (2014).

3 Ibid.

Australian Governments (COAG) should take the National Decision-Making Principles into account to regulate restrictive practices in the context of the NDIS.[4]

8.4 The ALRC also recommends that the Australian Government and COAG adopt a similar, national approach to the regulation of restrictive practices in other relevant sectors such as aged care and health care.

The use of restrictive practices in Australia

8.5 Restrictive practices involve the use of interventions by carers and service providers that have the effect of limiting the rights or freedom of movement of a person with disability, with the primary purpose of protecting the person or others from harm. These include restraint (chemical, mechanical, social or physical) and seclusion.[5]

8.6 Persons with disability who display 'challenging behaviour' or 'behaviours of concern' may be subjected to restrictive practices or medical intervention in a variety of contexts, including: supported accommodation and group homes; residential aged care facilities; rehabilitation centres; mental health facilities; hospitals; prisons; and schools.[6]

8.7 The limited available data from the Victorian Office of the Senior Practitioner accords with the international research that an estimated 10–15% of persons with disability will show 'behaviours of concern' and between 44–80% of them will be administered a form of chemical restraint in response to the behaviour.[7]

8.8 The Office of the Senior Practitioner found chemical restraint to be the most commonly used form of restraint.[8] Chemical restraint is reportedly widely used on people with dementia. The Department of Health and Ageing told the Senate Inquiry

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4 See Ch 3.

5 See, eg, definitions in: Australian Government, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (2014) 4; *Disability Act 2006* (Vic) s 3(1). For comment, see also: Philip French, Julie Dardel and Sonya Price-Kelly, 'Rights Denied: Towards a National Policy Agenda about Abuse, Neglect and Exploitation of Persons with Cognitive Impairment' (People with Disability Australia, 2009) [2.48]–[2.51]. See also submissions in relation to proposed changes to the definitions under the Proposed National Framework: NMHCCF and MHCA, *Submission 81*; NSW Council for Intellectual Disability, *Submission 33*; Physical Disability Council of NSW, *Submission 32*.

6 See, eg, Justice Connect and Seniors Rights Victoria, *Submission 120*; PWDA and Disability Rights Research Collaboration, *Submission 111*; National Association of Community Legal Centres and Others, *Submission 78*; Children with Disability Australia, *Submission 68*; Central Australian Legal Aid Service, *Submission 48*; Public Interest Advocacy Centre, *Submission 41*; Office of the Public Advocate (Vic), *Submission 06*; Office of the Public Advocate (Qld), *Submission 05*. See also Victorian Law Reform Commission, *Guardianship*, Final Report No 24 (2012) 318.

7 Eric Emerson, *Challenging Behaviour: Analysis and Intervention in People with Severe Intellectual Disabilities* (Cambridge University Press, 2001); Kathy Lowe et al, 'The Management and Treatment of Challenging Behaviours' (2005) 10 *Tizard Learning Disability Review* 34, cited in 'Chemical Restraint: What Every Disability Support Worker Needs to Know' (Office of the Senior Practitioner, Victoria, August 2008) 1. Victorian figures on behaviour support plans cited in Paul Ramcharan et al, 'Experiences of Restrictive Practices: A View from People with Disabilities and Family Carers' (Research Report, Office of the Senior Practitioner, 2009) 12.

8 'Chemical Restraint: What Every Disability Support Worker Needs to Know', above n 7.

into dementia that the use of drugs in dementia is higher than would be expected on clinical grounds alone:

> In February 2013 [the drug utilisation subcommittee] found that there is a high and inappropriate utilisation of antipsychotics in the elderly, especially in the case of two drugs: quetiapine and olanzapine, which are prescribed at a rate inconsistent with the age-specific prevalence of bipolar disease.[9]

8.9 Between 50–60% of people presenting challenging behavior in the United Kingdom are subjected to physical restraint;[10] those with multiple impairments and complex support needs may experience much higher levels of restrictive practices.

8.10 Surveillance may, in some circumstances, amount to a restrictive practice. The Office of the Public Advocate (Qld) reported that, in a census survey of 861 disability accommodation sites in 2013, 13% of them used some form of electronic monitoring of their residents. The majority of the residents subject to audio or visual surveillance had an intellectual disability and the reasons for surveillance included monitoring of the residents' health, the desire to safeguard residents from accidental harm, and the residents' challenging behaviours and self-harming behaviours.[11]

Improper use of restrictive practices

8.11 While restrictive practices are used in circumstances to protect from harm the person with disability or others around them, there are concerns that such practices can also be imposed as a 'means of coercion, discipline, convenience, or retaliation by staff, family members or others providing support'.[12]

8.12 Many stakeholders raised systemic issues across various sectors which result in inappropriate or overuse of restrictive practices.[13] A key explanation for the use of restrictive practices may be the lack of resources for positive behaviour management and multi-disciplinary interventions to 'challenging behaviours'. Such behaviours may be better understood as a 'legitimate response to difficult environments and situations' or 'adaptive behaviours to maladaptive environments'.[14]

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9 Commonwealth, *Committee Hansard*, Senate, 17 July 2013, 40–41 (Ms Adriana Platona).

10 Eric Emerson, 'The Prevalence of Use of Reactive Management Strategies in Community-Based Services in the UK' in David Allen (ed), *Ethical Approaches to Physical Interventions: Responding to Challenging Behaviour in People with Intellectual Disabilities* (BILD, 2003).

11 Office of the Public Advocate (Qld), *Submission 110*. See, attachment to the submission, 'Inquiry into the Use of Electronic Monitoring at Disability Accommodation Sites in Queensland' May 2014.

12 Disability Rights Now, *Civil Society Report to the United Nations on the Rights of Persons with Disabilities* (2012) [241].

13 See, eg, NMHCCF and MHCA, *Submission 81*; Australian Psychological Society, *Submission 60*; Disability Discrimination Legal Service, *Submission 55*; Central Australian Legal Aid Service, *Submission 48*; Physical Disability Council of NSW, *Submission 32*. See also National Mental Health Commission, 'A Contributing Life, the 2013 National Report Card on Mental Health and Suicide Prevention' (2013).

14 Paul Ramcharan et al, 'Experiences of Restrictive Practices: A View from People with Disabilities and Family Carers' (Research Report, Office of the Senior Practitioner, 2009) 2. See also Physical Disability Council of NSW, *Submission 32*.

8.13 As the Chief Executive Officer (CEO) of Alzheimer's Australia explained to the Senate Inquiry into dementia,[15] it is important to look beyond behaviours to understand the reasons for them:

> I think the secret to dementia care is actually very simple, and that is to look at the cause of a person's symptoms and not to respond to the symptoms themselves. If somebody is violent, they are not being violent because they are a nasty person. They are being violent because they are frustrated. They feel no purpose in life ... They do not know where they are. They feel disoriented. They may feel very depressed. They may be suffering psychosis. They may be losing their words. They may not be able to communicate. You put all those things together and think of how you would react and then you can start to translate it into your own behaviours.[16]

8.14 There is also evidence that what constitutes a restrictive practice is contested, which may result in inadvertent and misguided use of restrictive practices. A representative of the Royal Australian College of General Practitioners told the Senate Inquiry into dementia:

> Many facilities have a locked dementia unit so people cannot actually get out, where there might be a busy road or something like that. For the night people may be put in a low bed that is a little bit difficult to get out of so that they cannot wander easily. It is not actually a restraint as such but it does provide a physical barrier to wandering. So there are some things like that that do not feel anything like being tied up but that do minimise behaviour that might cause that resident some harm.[17]

8.15 In contrast, Caxton Legal Centre described a similar scenario in a dementia unit as a clear instance of restrictive practices, submitting a case involving 'Mrs H', a woman in her mid-70s and of a culturally and linguistically diverse background, who called the centre to complain that she had been misdiagnosed with Alzheimer's disease and had spent 10 months in 'prison'.[18]

8.16 High level definitions in the National Framework have set out the agreed understanding of restrictive practices and clarify that a restraint need not be physical, mechanical or chemical, but can also be psychosocial and involve the use of 'power-control' strategies.[19] A case study submitted by Justice Connect illustrated this point:

> An older man was frustrated with a rehabilitation facility that would not allow him to return home in circumstances where his children did not support his desire to do so. The man's capacity was not impaired, but the facility was concerned about their duty of care. The man was told that if he attempted to leave the facility, the police would be called.[20]

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15 Senate Committee on Community Affairs, Parliament of Australia, *Care and Management of Younger and Older Australians Living with Dementia and Behavioural and Psychiatric Symptoms of Dementia* (2014).

16 Commonwealth, *Committee Hansard*, Senate, 17 July 2013, 31 (Mr Glenn Rees).

17 Commonwealth, *Committee Hansard*, Senate, 16 December 2013, 36 (Professor Constance Dimity Pond); see also evidence by the General Manager of Residential Care, HammondCare: Commonwealth, *Committee Hansard*, Senate, 17 July 2013, 17 (Ms Angela Raguz).

18 Caxton Legal Centre, *Submission 67*.

19 Australian Government, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (2014).

20 Justice Connect and Seniors Rights Victoria, *Submission 120*.

Australia's international obligations

8.17 Australia, as a State Party, has obligations under the *United Nations Convention on the Rights of Persons with Disabilities*[21] (CRPD) and the *United Nations Convention against Torture*.[22]

8.18 The Australian Civil Society Response, as part of Australia's appearance before the United Nations Committee on the Rights of Persons with Disabilities (UNCRPD) in 2013, expressed concern that persons with disabilities, especially cognitive impairment and psychosocial disability, are 'routinely subjected to unregulated and under-regulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraint and seclusion'.[23]

8.19 Following this report, the UNCRPD recommended that Australia

> take immediate steps to end such practices, including by establishing an independent national preventive mechanism to monitor places of detention—such as mental health facilities, special schools, hospitals, disability justice centres and prisons—in order to ensure that persons with disabilities, including psychosocial disabilities, are not subjected to intrusive medical interventions.[24]

8.20 Article 12 of the CRPD protects the right of persons with disabilities to have equal recognition before the law. Articles 14, 15 and 16 provide their right to liberty and security of person, freedom from torture or cruel, inhuman or degrading treatment or punishment and freedom from exploitation, violence and abuse.

8.21 Stakeholders suggested that some forms of restrictive practices could even amount to torture.[25] Australia is a party to the United Nations Convention against Torture[26] and also a signatory to the Optional Protocol on the Convention against Torture (OPCAT).[27] However, Australia has not yet ratified the OPCAT which requires States to establish a national system of inspections of all places of detention to ensure compliance with the Convention against Torture.[28]

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21 *UN Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008).

22 *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 10 December 1984, 1465 UNTS 85 (entered into force 26 June 1987).

23 Disability Rights Now, 'Australian Civil Society Parallel Report Group Response to the List of Issues, CRPD 10th Session Dialogue with Australia, Geneva' (September 2013) 13.

24 Committee on the Rights of Persons with Disabilities, 'Concluding Observations on the Initial Report of Australia, Adopted by the Committee at Its 10th Session (2–13 September 2013)' (United Nations, 4 October 2013) [35]–[36].

25 See PWDA and Disability Rights Research Collaboration, *Submission 111*; Queensland Advocacy Incorporated, *Submission 45*; Mental Health Coordinating Council, *Submission 07*.

26 *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 10 December 1984, 1465 UNTS 85 (entered into force 26 June 1987).

27 *Optional Protocol to United Nations Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, UN Doc A/61/611 (entered into force 3 May 2008).

28 Australian Human Rights Commission, *Optional Protocol to the Convention against Torture (OPCAT)* <www.humanrights.gov.au>.

8.22 A national approach to restrictive practices that includes monitoring of detention and other deprivations of liberty could assist in meeting Australia's obligations under OPCAT, if it were to ratify the agreement.

8.23 The Offices of the Public Advocate (South Australia and Victoria) (OPA (SA and Vic)) noted the omission of detention as a restrictive practice from the National Framework.[29] Stakeholders emphasised that disability accommodation with locked doors—where people cannot leave unless they are escorted—should be considered places of detention.[30] Arguably, detention constitutes a criminal offence or otherwise fits within the high level definition of 'seclusion' in the National Framework as the sole confinement of a person with disability in a room or physical space at any hour of the day or night where voluntary exit is prevented, implied, or not facilitated.[31]

8.24 The ALRC considers that a national approach should clarify the circumstances under which detention would be a crime or restrictive practice. The ALRC commends the existing Victorian[32] and South Australian[33] models, which prevent restrictions on people's liberty or freedom of movement, as useful in informing a national approach to restrictive practices that explicitly addresses detention in schools, residential treatment facilities and correctional institutions.

8.25 The People with Disability Australia and Disability Rights Research Collaboration proposed that 'a national dialogue' with people with disability and their representatives be held to consider all issues relating to the 'use of and protection from restrictive practices'.[34] Such a dialogue would include examination of the relationship between restrictive practices and torture, Australian's international obligations under OPCAT and the utilisation of evidence of restrictive practices administered on children with disability that may be produced in the Royal Commission into Institutional Responses to Child Sexual Abuse.[35] Noting the dearth of empirical studies of the views of people with disability and family carers, the joint submission contended that a nationally consistent framework on restrictive practices must be shaped by their lived experiences.[36]

A patchwork of existing laws and policies

8.26 Stakeholders expressed significant concerns about the unregulated use of restrictive practices[37] and were supportive of the ALRC's proposal for national reform.[38]

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29 Offices of the Public Advocate (SA and Vic), *Submission 95*.
30 See, eg, PWDA and Disability Rights Research Collaboration, *Submission 111*.
31 See, French, Dardel and Price-Kelly, above n 5, 64–65; 97–98.
32 *Disability Act 2006* (Vic) pt 8.
33 See policies of Disability Services and OPA (SA); *Guardianship and Administration Act 1993* (SA).
34 PWDA and Disability Rights Research Collaboration, *Submission 111*.
35 Ibid.
36 Ibid.
37 See, eg, National Association of Community Legal Centres and Others, *Submission 78*; Central Australian Legal Aid Service, *Submission 48*; NSW Council for Intellectual Disability, *Submission 33*; Physical Disability Council of NSW, *Submission 32*; Office of the Public Advocate (Vic), *Submission 06*; Office of the Public Advocate (Qld), *Submission 05*.

8.27 Regulation of restrictive practices occurs at a state and territory level under disability services and mental health legislation, and under a range of policy directives, statements and guidance materials. There is substantial discrepancy in the regulation of restrictive practices across jurisdictions, and the numerous frameworks 'conspire to make the legal framework in this area exceedingly complex'.[39]

8.28 Robust regulation that applies specifically to restrictive practices occurs in Victoria, Queensland and Tasmania through disability services legislation.[40] The approach in other jurisdictions includes policy-based frameworks, voluntary codes of practice, and regulation as an aspect of guardianship .[41]

8.29 In the context of the mental health system, Victoria and Queensland have detailed provisions relating to restrictive practices, combined with minimum standard guidelines[42] and a policy statement.[43] Legislative provisions are less prescriptive in other jurisdictions.[44] In NSW, the use of restrictive practices is regulated by a lengthy policy directive.[45] Mental health legislation is an area of ongoing review and reform, with implications for the regulation of restrictive practices.[46]

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38 National Association of Community Legal Centres, *Submission 127*; Advocacy for Inclusion, *Submission 126*; National Mental Health Consumer & Carer Forum, *Submission 100*; Office of the Public Advocate (SA and Vic), *Submission 95*; Central Australian Legal Aid Service, *Submission 48*; Public Interest Advocacy Centre, *Submission 41*; Office of the Information Commissioner, Queensland, *Submission 20*; Carers Queensland Australia, *Submission 14*.

39 Michael Williams, John Chesterman and Richard Laufer, 'Consent vs Scrutiny: Restrictive Liberties in Post-Bournewood Victoria' (2014) 21 *Journal of Law and Medicine* 1.

40 *Disability Act 2006* (Vic); *Disability Services (Restrictive Practices) and Other Legislation Amendment Act 2014* (Qld); *Disability Services Act 2011* (Tas).

41 For example, in NSW, guidelines govern the use of restrictive practices in relation to adults: NSW Department of Family and Community Services, *Behaviour Support Policy*, Version 4.0 (March 2012). In addition, the use of a distinct number of restrictive practices requires completion of a documented plan, involving authorisation by an internal Restricted Practices Authorisation mechanism. Guardians appointed under the *Guardianship Act 1987* (NSW) may be authorised to consent to the use of restrictive practices for people over 16 years of age. Restrictive practices in relation to children are governed by *Children and Young Persons (Care and Protection) Act 1998* (NSW) and *Children and Young Persons (Care and Protection) Regulation 2012* (NSW). The WA Disability Services Commission is reviewing its 2012 Voluntary Code of Practice for the Elimination of Restrictive Practices in 2014.

42 *Mental Health Act 1986* (Vic) ss 81–82; Victorian Chief Psychiatrist's Guideline, *Seclusion in Approved Mental Health Services* (2011).

43 *Mental Health Act 2000* (Qld) pt 4A; Queensland Health Department, *Policy Statement on Reducing and Where Possible Eliminating Restraint and Seclusion in Queensland Mental Health Services* (2008). See also, Queensland Health Department, *Mental Health Act 2000 Resource Guide* (2012).

44 See, eg, *Mental Health Act 2009* (SA) ss 7(h), 90, 98; *Mental Health Act 1996* (WA) ss 116–124; *Mental Health and Related Services Act 1998* (NT) ss 61–62; *Mental Health (Treatment and Care) Act 1994* (ACT).

45 NSW Health, *Aggression, Seclusion & Restraint in Mental Health Facilities in NSW*, Policy Directive (June 2012).

46 In Tasmania, the *Mental Health Act 2013* (Tas) which regulates restrictive practices, commenced on 17 February 2014; and the new *Mental Health Act 2014* (Vic) commenced on 1 July 2014. There are also several reviews of mental health legislation in a number of jurisdictions: in ACT, the second exposure draft of the *Mental Health (Treatment and Care) Act 1994* (ACT) was drafted in 2013; in WA, the Mental Health Bill 2013 (WA) was adopted by the Legislative Assembly on 10 April 2014; review of the Bill in the Legislative Council is pending; in SA, the Department of Health has completed public consultation on the *Mental Health Act 2009* (SA) and its report to Parliament is expected in June 2014; in Queensland, submissions to a review focusing on areas for improvements to the *Mental Health Act 2000* (Qld) closed in August 2013; in NSW, a report was tabled in Parliament in May 2013: 'Review of the NSW Mental

8.30 Since March 2014, there is also a national agenda for consistency and standardisation in the regulation of restrictive practices in the form of the National Framework. The National Framework represents a united commitment 'to the high-level guiding principles and implementation of the core strategies to reduce the use of restrictive practices in the disability service sector'.[47]

8.31 The National Framework is intended to work within existing legislative arrangements to establish minimum standards in relation to the regulation of restrictive practices. It embodies the agreement by all jurisdictions that, by 2018, all disability service providers with NDIS funding will implement six core strategies to reduce the use of restrictive practices.[48] The COAG Disability Reform Council indicated that these core strategies will guide governments in the development of national quality and safeguards system for the NDIS.[49] Until such a system is developed, state and territory quality assurance and safeguards frameworks will apply.[50]

8.32 The NDIS system will be underpinned by the revised National Standards for Disability Services.[51] It is expected that, from 2018, this national system will govern the use of restrictive practices affecting NDIS participants to ensure their access to disability services is in accordance with human rights principles.

8.33 There are also relevant guidelines at a national level including those issued by the Royal Australian and New Zealand College of Psychiatrists,[52] the Australian Psychological Association,[53] Alzheimer's Australia[54] and the Australian Government Department of Health with respect to aged care.[55]

8.34 The complex web of state, territory and national laws, policies, codes and guidelines has been much criticised. The OPA (SA and Vic) described the existing

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Health Act 2007: Report for NSW Parliament, Summary of Consultation Feedback and Advice' (NSW Ministry of Health, May 2013). See also Ch 10.

47 Australian Government, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (2014) 2.

48 The six core strategies are: person-centred focus; leadership towards organisational change; use of data to inform practice; workforce development; use of restraint and seclusion reduction tools; and debriefing and practice review. See further Australian Government, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (2014).

49 COAG Disability Reform Council, *Meeting Communiqué*, 21 March 2014.

50 Australian Government, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (2014) 2–3; *Intergovernmental Agreement on the NDIS Launch*, 7 December 2012.

51 National Disability Insurance Scheme, *Quality and Best Practice Framework* <www.ndis.gov.au>. The revised National Standards for Disability Services were endorsed by all governments on 18 December 2013. The six standards are: Rights; Participation and Inclusion; Individual Outcomes; Feedback and Complaints; Service Access; and Service Management.

52 Royal Australian and New Zealand College of Psychiatrists, *Statements and Guidelines* <www.ranzcp.org>.

53 'Evidence-Based Guidelines to Reduce the Need for Restrictive Practices in the Disability Sector' (Australian Psychological Society, 2011).

54 Alzheimer's Australia, *Quality Dementia Care Papers* <www.fightdementia.org.au>.

55 See, eg, Department of Health, *Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care* (2012). See also Senate Committee on Community Affairs, Parliament of Australia, *Care and Management of Younger and Older Australians Living with Dementia and Behavioural and Psychiatric Symptoms of Dementia* (2014).

regulatory efforts as being 'piecemeal' across the country and insufficient 'to protect and promote the rights of people who are subject to restrictive interventions'.[56]

8.35 However, recent initiatives at a national level—the National Framework; the development of a national quality and safeguards system for the NDIS; the National Seclusion and Restraint Project[57] and an Australian Research Council Linkage Project[58]—provide a timely opportunity to inform and ground a uniform approach to regulating restrictive practices that applies in a broader range of settings than just the disability sector.

A national approach to regulation

Recommendation 8–1 The Australian Government and the Council of Australian Governments should take the National Decision-Making Principles into account in developing the national quality and safeguards system, which will regulate restrictive practices in the context of the National Disability Insurance Scheme.

The National Framework and the NDIS

8.36 The ALRC recommends the development of the NDIS system take into account the National Decision-Making Principles. Among other things, this would mean that provisions regulating restrictive practices would: encourage supported decision-making before the use of such practices; provide for the appointment of representative decision-makers only as a last resort; and require that the will, preferences and rights of persons direct decisions about any use of restrictive practices.[59]

8.37 The ALRC recognises the complexity of incorporating supported decision-making into regulation of restrictive practices, but considers that art 12 of the CRPD should help inform any future national approach to restrictive practices—in particular, by ensuring that decisions about restrictive practices are based on the 'will, preferences and rights' of the person subjected to them.

8.38 The National Framework is an important platform for reform and embodies the commitment of all jurisdictions to collaborate and evaluate progress against a set of principles and strategies. The National Framework is based on the human rights encapsulated in the CRPD, a person-centred focus and international research on best practice.

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56 Offices of the Public Advocate (SA and Vic), *Submission 95*.

57 National Mental Health Commission, *National Seclusion and Restraint Project* <www.mentalhealthcommission.gov.au>.

58 Associate Professor Renata Kokanovic of Monash University is leading an ARC Linkage Project for 2013–2016 investigating options for supported decision-making to enhance recovery of people with severe mental health problems.

59 See Ch 3.

8.39 The National Framework incorporates guiding principles, including reference to a 'Person-Centred Focus', which states that

> people with disability (with the support of their guardians or advocates where required) are the natural authorities for their own lives and processes that recognise this authority in decision making, choice and control should guide the design and provision of services.[60]

8.40 The National Framework also provides for 'maximum respect for a person's autonomy', including:

> i. recognising the presumption of capacity for decision making;
>
> ii. seeking a person's consent and participation in decision making (with support if necessary) prior to making a substitute decision on their behalf; and
>
> iii. engaging the appropriate decision maker and seeking consent where appropriate, where a decision must be made on behalf of a person.[61]

8.41 The corresponding core strategy states that one of the key implementation areas is the 'availability of tools to assist people with disability and their guardians or advocates (where appropriate) to participate in decision making'.[62]

8.42 However, the National Framework has been criticised for omitting reference to art 12 of the CRPD and, in particular, the obligation on Australia to 'take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity'.[63]

8.43 The National Decision-Making Principles are a vehicle for the Australian Government and COAG to give effect to the right of persons with disability to have equal recognition before the law captured in art 12 of the CRPD. The National Decision-Making Principles make prominent the need to respect the will, preferences and rights of persons with disability in making decisions affecting their lives.

The National Decision-Making Principles

8.44 Taking the National Decision-Making Principles into account in the context of restrictive practices would mean that, as far as possible, decisions about restrictive practices should ultimately be those of the person potentially subject to them.

8.45 The National Decision-Making Principles can be interpreted as being consistent with best practice alternatives to restrictive practices, which consider the causes of behaviour and plan for positive behaviour support.[64] For example, a person may require support to make decisions about the use of restrictive practices under a behaviour support plan.

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60 Australian Government, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (2014) 7.

61 Ibid.

62 Ibid 10.

63 *UN Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008) art 12(3); Offices of the Public Advocate (SA and Vic), *Submission 95*.

64 See, Paul Ramcharan et al, 'Experiences of Restrictive Practices: A View from People with Disabilities and Family Carers' (Research Report, Victorian Officer of the Senior Practitioner, May 2009).

8.46 The story of 'Vincent' demonstrates the importance of providing for supported decision-making and complaint mechanisms:

> Vincent is 32 and lives in a major city. He has an intellectual disability with complex behaviour. He has lived in supported accommodation since he was a teenager. His parents, Maria and Carl, are increasingly frail and visit him as often as they can. One visit, they become concerned about the amount of medication used for Vincent. They raise their concerns with the support worker who says that the behaviour management recommended is too hard as there aren't enough workers on the evening shifts ... Maria and Carl begin to worry that making a complaint may make matters worse for Vincent, but the manager explains that the formal process helps the service understand issues and make improvements. They call Hannah (an independent advocate) for advice. At their request, Hannah joins them for a meeting with the service. The staff say that Vincent has become increasingly violent and they are concerned about their safety and the safety of other residents.[65]

8.47 The management of Vincent's behaviour of concern requires a considered, multi-pronged response:

> The family and the service agree that they need to update Vincent's behaviour support plan, to support him earlier. The service agrees that workers need extra training on behaviour management, to avoid the use of medication. The service reviews its use of restrictive practices and organises training to improve behaviour support planning and implementation, and working with families to plan and review behaviour support.[66]

8.48 An NDIS system that is informed by the National Decision-Making Principles may enhance the prospects for Vincent to directly express his will and preferences, through having the right to communication support from anyone of his choice—parents, carers, fellow residents or independent advocates.

8.49 Supported decision-making could also help reduce and avoid the use of restrictive practices for persons with disability. Research has found that many persons with disability feel unsafe in the situations and environments they are faced with.[67] Many find it challenging to maintain their privacy and safety where staff numbers are low or where there is no active engagement.[68] They may rightly feel angry when services are not delivered but often feel powerless in disability and mental health facilities. Therefore, they may communicate their views about their environments and situations through their challenging behaviours.[69]

8.50 If the NDIS system is consistent with the National Decision-Making Principles, a family member or carer of an NDIS participant with intellectual disability could help to communicate to the disability service provider, for instance, the reasons behind any 'behaviours of concern'—such as, discomfort in an environment, boredom with an

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65 Department of Social Services, *National Standards for Disability Services Stories* (January 2014) <http://www.dss.gov.au>.

66 Ibid.

67 Ramcharan et al, 'Experiences of Restrictive Practices: A View from People with Disabilities and Family Carers', above n 64.

68 PWDA and Disability Rights Research Collaboration, *Submission 111*.

69 Ibid.

activity or strong aversions to certain food. Adjusting the environmental factors or stimuli may eliminate or moderate the need for any restraints or seclusion to be used.

Communication of will and preferences

8.51 Communication is crucial to a supported decision-making model.[70] Loretta Woolston identified the lack of specialised communication support as a decisive issue for people with complex communications needs in relation to restrictive practices:

> complex communications consumers of Disability Restrictive Practices (RP), seclusion, containment and chemical restraint have little to no systemic communication systems to assist and support them to participate in their health, legal and complaint systems decision making. They are discriminated against by the omission or lack of professional interpreter and translating services as currently provided by the Australian, states and territories governments to aboriginal, deaf or linguistically challenged persons.[71]

8.52 Silence from or acquiescence by persons with disability is taken as consent when this behaviour may in fact be the effect of disempowerment, institutionalisation and social isolation. Jo Watson's research on the communication of people with severe and profound disability demonstrates that it is possible to discern their wishes and preferences through the investment of time and effort.[72]

8.53 Support should also be available for people who do not have family or friends who can assist them in communicating their will and preferences. In some decision-making, the 'representative' of the person—a state guardian, administrator or a Commonwealth representative should be directed by the person's will, preferences and rights in making decisions for them.

8.54 Advance care directives may help determine a person's will and preferences. The OPA (SA and Vic) submitted that having support measures in place would be useful in the care management of people with disability.

> A person with a mental illness who has a Ulysses agreement may be calmer because of an effective pre-planned strategy to deal with distress when unwell; and a person with an intellectual disability who can plan and control their life and has necessary supports will be less likely to be in the types of situation that lead to restrictive practices, such as overcrowding and boredom.[73]

8.55 The OPA (SA and Vic) expressed some concerns about how supported decision-making in relation to consent to the use of restrictive practices will be applied under state and territory mental health law or disability legislation.[74] The ALRC recommends review of these state and territory laws.[75] The principal aims of such a review would be

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70 See Ch 3.

71 L Woolston, *Submission 89*; Loretta Woolston, Submission No 303 to the Senate Committee on Community Affairs, *Inquiry into the Prevalence of Different Types of Speech, Language and Communication Disorders and Speech Pathology Services in Australia*, 2014.

72 Scope, *Submission 88*.

73 Offices of the Public Advocate (SA and Vic), *Submission 95*; John Brayley, 'Your Right to Know: Consumer and Carer Participation and Involuntary Mental Health Care', *MIFSA News*, April–May 2011.

74 Offices of the Public Advocate (SA and Vic), *Submission 95*.

75 See Ch 10.

to encourage supported decision-making, and to shift from a best interests test to one directed by a person's will, preferences and rights.[76]

8.56 In the ALRC's view, a distinction should be maintained between lawful substitute consent to the use of the restrictive practice by a guardian or other authorised person and the support provided by a family member or carer to the person with disability in determining their will and preferences.

8.57 It is expected that, in a majority of cases, supporters will help discern a person's will and preferences concerned with restrictive practices. However, the NDIS system and any other national approaches must also make provision for situations where a person does not have informal support or it is otherwise impossible to determine their will and preferences. The ALRC recommends that in these cases, the human rights relevant to the situation apply in making decisions regarding restrictive practices.[77]

8.58 The ALRC disputes the assertion that if a person can be supported to give consent to a restrictive practice, then they may not be in need of restraint or seclusion.[78] The 'level of insight' into one's behaviour,[79] often understood as mental capacity, is not determinative of a person's capacity to consent to or refuse decisions about their bodily integrity, liberty, freedom, wills and preferences. This is because a person with an intellectual, cognitive or psychosocial disability may clearly express their will and preferences directly themselves at the time of the proposed use of the restrictive practice, have done so previously or through communication support, without needing to meet a certain level of mental capacity. The National Decision-Making Principles embody this stance.

8.59 PWDA and the Disability Rights Research Collaboration expressed concern that the initiatives to regulate, rather than eliminate, restrictive practices legitimise potentially serious breaches of human rights.[80] They cautioned that 'a perverse outcome' may result if a national framework enabled people with disability to consent to very serious breaches of their fundamental rights.[81]

8.60 The ALRC agrees that 'reforms to the legal framework regarding legal capacity should be aiming to reduce and limit the potential for these further rights violations to occur'.[82] A national approach to regulating restrictive practices is the first phase in a longer-term, iterative process towards the elimination of any rights violations against persons with disability. A stepped model is needed, along with rights education and resources devoted to guidance and training of persons with disability, their supporters and representatives.

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76 For prior consideration of the role of state and territory appointed decision-makers in relation to restrictive practices, see, eg, Victorian Law Reform Commission, *Guardianship*, Final Report No 24 (2012); French, Dardel and Price-Kelly, above n 5; Michael Williams, John Chesterman and Richard Laufer, above n 39.

77 See Ch 3.

78 NSW Government, *Submission 135*.

79 Ibid.

80 PWDA and Disability Rights Research Collaboration, *Submission 111*.

81 Ibid.

82 Ibid.

8.61 Many stakeholders emphasised the importance of safeguards in the use of restrictive practices.[83] PIAC proposed that any national or nationally consistent approach should ensure that restrictive practices

> are only implemented as a last resort; are implemented for the least amount of time possible; are recorded, monitored and reviewed; have tight safeguards in place that are focused on minimising risk to staff, patients, carers and family; and are undertaken with a focus on ensuring decency, humanity and respect at all stages.[84]

8.62 Taking the National Decision-Making Principles and the Safeguards Guidelines into account in the regulation of restrictive practices would mean that any representative decision-making would be in a form least restrictive of the person's human rights; appealable; and subject to regular, independent and impartial monitoring and review.

A national approach in other sectors

Recommendation 8–2 The Australian Government and the Council of Australian Governments should develop a national approach to the regulation of restrictive practices in sectors other than disability services, such as aged care and health care.

8.63 The National Framework currently applies only to the disability services sector. The ALRC acknowledges the ongoing work of the Disability Reform Council,[85] but recommends that the Australian Government and the COAG also develop a national approach to restrictive practices across other relevant sectors.

8.64 Stakeholders were very supportive of the ALRC's proposal for a national or nationally-consistent approach to restrictive practices.[86] The National Mental Health Consumer and Carer Forum and the Mental Health Council of Australia (NMHCCF and MHCA), for example, recommended the development and adoption of

> nationally consistent legislation governing restrictive practices, of which seclusion and restraint are included, be developed and adopted across all states and territories. This legislation should include standardised terminology and definitions and set clear and effective practice standards.[87]

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83 NACLC and PWDA, *Submission 134*; Illawarra Forum, *Submission 124*; National Association of Community Legal Centres and Others, *Submission 78*.

84 Public Interest Advocacy Centre, *Submission 41*. See also Senate Committee on Community Affairs, Parliament of Australia, *Care and Management of Younger and Older Australians Living with Dementia and Behavioural and Psychiatric Symptoms of Dementia* (2014) recs 14, 15.

85 The Disability Policy Group is developing a national framework for quality and safeguards and is expected to report to the Disability Reform Council and the COAG by early 2015: NSW Government, *Submission 135*.

86 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Discussion Paper No 81 (2014) Proposal 8–1.

87 NMHCCF and MHCA, *Submission 81*.

8.65 The Disability Discrimination Legal Service (DDLS) recommended that a national framework or approach 'be binding on organisations that receive federal funding, via inclusion in service agreements'.[88] The OPA (Vic) suggested the creation of a National Senior Practitioner (mirroring the role of Victoria's Senior Practitioner) to monitor and audit the use of restrictive practices in aged care facilities.[89]

8.66 The OPA (SA and Vic) identified the challenge of reducing and eliminating the use of restrictive practices in Australia is exacerbated by 'the lack of uniform legislative controls and reporting requirements and the absence of equivalent key players across all jurisdictions'.[90] The solution may lie in 'clear, uniform legislative controls and reporting requirements' for the use of restrictive interventions in all government funded and supported accommodation services, modelled on provisions of the *Disability Act 2006* (Vic).[91] The OPA (SA and Vic) called for coverage of both federal and state funded and supported accommodation, including aged care facilities, schools and prisons.[92]

8.67 Stakeholders stressed the need for a national approach beyond the disability services sector and the NDIS.[93] Disability Rights Now recommended that, due to the use of restrictive practices in a range of contexts, 'any framework on restrictive practices needs to recognise this, and be part of a wider overarching strategy addressing violence and abuse of people with disability in general'.[94]

8.68 The ALRC recommends the regulation of restrictive practices cover the use of restrictive practices in a range of settings.[95] This is particularly important given that persons with disability may experience restrictive practices in a variety of contexts, including: supported accommodation and group homes; residential aged care facilities; mental health facilities; hospitals; prisons; and schools.[96] Harmonising laws and reducing red-tape related to restrictive practices in all relevant sectors, and not just disability services, may result in cost benefits for service providers around Australia.[97]

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88 Disability Discrimination Legal Service, *Submission 55* attachment 1. See also National Association of Community Legal Centres, *Submission 127*; Offices of the Public Advocate (SA and Vic), *Submission 95*; National Association of Community Legal Centres and Others, *Submission 78*; Carers Queensland Inc, *Submission 14*.

89 Office of the Public Advocate (Vic), *Submission 06*.

90 Offices of the Public Advocate (SA and Vic), *Submission 95*.

91 Claire Spivakovsky, 'Restrictive Interventions in Victoria's Disability Sector: Issues for Discussion and Reform' (Office of the Public Advocate, Victoria, August 2012); *Disability Act 2006* (Vic) pt 7.

92 Offices of the Public Advocate (SA and Vic), *Submission 95*.

93 See, eg, National Association of Community Legal Centres, *Submission 127*.

94 Disability Rights Now, above n 23, 14.

95 See, eg, Disability Discrimination Legal Service, Submission 55 attachment 1. See also P French, J Dardel and S Price-Kelly, 'Rights Denied: Towards a National Policy Agenda about Abuse, Neglect and Exploitation of Persons with Cognitive Impairment' [2009] *People with Disability Australia*.

96 See, eg, National Association of Community Legal Centres and Others, *Submission 78*; Children with Disability Australia, *Submission 68*; Central Australian Legal Aid Service, *Submission 48*; Public Interest Advocacy Centre, *Submission 41*; Office of the Public Advocate (Vic), *Submission 06*; Office of the Public Advocate (Qld), *Submission 05*.

97 See, KinCare Services, *Submission 112*.

8.69 Concerns about restrictive practices in aged care were highlighted by several stakeholders, as well as the Senate inquiry into dementia.[98] The Senate inquiry recommended 'the Commonwealth develop, in consultation with dementia advocates and service providers, guidelines for the recording and reporting on the use of all forms of restraints in residential facilities'.[99] Similarly, the Office of the Public Advocate (Vic) highlighted concerns about 'the high use of restrictive interventions on residents of aged care facilities' and stated that it 'would like to see greater regulation and on-site auditing of this practice'.[100]

8.70 Justice Connect and Senior Rights Victoria supported national regulation in aged care 'due to the failure of current laws to provide a comprehensive framework' for decisions affecting people with 'disabilities solely related to ageing'.[101]

8.71 The OPA (SA and Vic) submitted there is an 'alarming lack of Commonwealth oversight' over the high use of restrictive interventions, particularly chemical restraints, on residents of aged care facilities. They urged the ALRC to

> carefully consider how the Commonwealth decision-making model can both provide for supported decision-making arrangements, and establish protective mechanisms in relation to the use of restrictive practices in aged care facilities.[102]

8.72 There are two comprehensive guidelines issued by the Department of Health in relation to supporting restraint-free practices in residential aged care and community aged care.[103] However, stakeholders expressed strong support for binding national regulation rather than just guidelines.

8.73 The use of restrictive practices on people with mental illness in a variety of situations is recognised by the National Seclusion and Restraint Project. The Project extends beyond hospitals and health facilities to include community, custodial and ambulatory settings.[104] The national study seeks to capture best practice in reducing or eliminating seclusion and restraint around Australia and it may help produce an evidence base upon which a national approach could be developed.[105]

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98 Senate Committee on Community Affairs, Parliament of Australia, *Care and Management of Younger and Older Australians Living with Dementia and Behavioural and Psychiatric Symptoms of Dementia* (2014) rec 14.

99 Ibid.

100 Office of the Public Advocate (Vic), *Submission 06;* Office of the Public Advocate (Qld), *Submission 05*.

101 Offices of the Public Advocate (SA and Vic), *Submission 95*.

102 Office of the Public Advocate (SA and Vic), *Submission 95*. See also Office of the Public Advocate (SA), *Submission 17*.

103 Department of Health, *Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care*, above n 1; Department of Health, *Decision-Making Tool: Supporting a Restraint Free Environment in Community Aged Care*, above n 1.

104 National Mental Health Commission, *National Seclusion and Restraint Project*, above n 57.

105 The Project was established by the National Mental Health Commission in partnership with the Mental Health Commission of Canada and a number of key Australian bodies, including the Australian Human Rights Commission. The National Mental Health Commission has also 'engaged an interdisciplinary team of researchers from the University of Melbourne to look at best practice in reducing and eliminating the use of seclusion and restraint in relation to mental health issues and help identify good practice treatment approaches. The research team aims to identify what factors drive current practice in service delivery to evaluate how these factors can lead to best practice': National Seclusion and Restraint Project,

8.74 Smoke-free hospitals may be environmental restraints on people with mental illness, particularly involuntary patients, if no exemption for them applies.[106] The NMHCCF asserted that any service that imposes smoking bans on consumers at a time when they are acutely unwell are 'engaging in cruel and inhumane treatment and demonstrating a complete indifference to the distress of this consumer group'.[107] Furthermore, non-compliance with anti-smoking policies by patients appears to trigger the use of restrictive practices and rates of seclusion.[108]

Other issues

8.75 The ALRC does not recommend specific mechanisms for enforcing regulation of restrictive practices, recognising the many options for reform and the expertise held by Australian Government departments and agencies, COAG and others in this area.

8.76 However, it is worth noting that stakeholders expressed various views on the form a national approach should take.[109] Many of them submitted that some binding form of regulation is preferred or necessary. For example, the DDLS submitted that it would be 'insufficient' to simply have a framework and hope that the relevant organisations will abide by its 'guidelines'.[110]

8.77 The NMHCCF warned against 'the illusion of compliance' in applying a national framework to service agreements that are not enforced.[111] People with Disabilities WA and the Centre for Human Rights Education preferred regulation over voluntary codes, like that in Western Australia,[112] because voluntary codes provide useful guidance but cannot guarantee implementation by all service providers.[113]

8.78 Legal Aid Queensland favoured a legislative scheme which imposed a positive duty on carer organisations to provide all practical help to support an adult with impaired capacity with respect to decisions about restrictive practices.[114] This is because, without such an obligation, there has only been a 'minority of cases' where

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Project Information <www.socialequity.unimelb.edu.au>. See also, the ARC Linkage Project on options for supported decision-making to enhance recovery of people with severe mental health problems.

106 National Mental Health Consumer & Carer Forum, *Submission 100*. An estimated 32% of people with a mental illness smoke tobacco compared to 18% of the general population: Sane Australia, *Smoking and Mental Illness: Factsheet 16* (2014) <www.sane.org>.

107 'Advocacy Brief: Smoking and Mental Health' (National Mental Health Consumer and Carer Forum, February 2014).

108 National Mental Health Consumer & Carer Forum, *Submission 100*; Senate Committee on Community Affairs, Parliament of Australia, *Care and Management of Younger and Older Australians Living with Dementia and Behavioural and Psychiatric Symptoms of Dementia* (2014).

109 People with Disabilities WA and Centre for Human Rights Education, *Submission 133*; National Association of Community Legal Centres, *Submission 127*; PWDA and Disability Rights Research Collaboration, *Submission 111*; Offices of the Public Advocate (SA and Vic), *Submission 95*; Mental Health Coordinating Council, *Submission 94*; Disability Discrimination Legal Service, *Submission 55*.

110 Disability Discrimination Legal Service, *Submission 55* attachment 1.

111 National Mental Health Consumer & Carer Forum, *Submission 100*.

112 'Voluntary Code of Practice for the Elimination of Restrictive Practices' (Disability Services Commission of Western Australia, September 2012).

113 People with Disabilities WA and Centre for Human Rights Education, *Submission 133*.

114 Citing the *Mental Capacity Act 2005* (UK) s 1(3): Legal Aid Qld, *Submission 141*.

their lawyers have successfully advocated for funded carers to consider the proposed use of restrictive practices and develop supported decision-making for the adult.[115]

8.79 The OPA (SA and Vic) supported a comprehensive approach that addresses current gaps across sectors and jurisdictions which incorporates legislation and national guidelines, codes of practice or policy directives, as well as education, training and guidance.[116] Other submissions called for laws to incorporate key principles[117] or to mandate training that will complement the use of strategies to reduce restrictive practices such as positive support behaviour plans.[118]

8.80 Monitoring the use of restrictive practices is an essential element of any regulatory framework. The Australian Government and COAG's commitment to implement a data monitoring system, that integrates existing arrangements by 2018 under the National Framework, may form the basis for the design of a national mechanism for enforcement in relation to restrictive practices in Australia. Stakeholders suggested some 'touchstones' for monitoring the use of restrictive practices may relate to the veracity of the data, specifically, the accuracy in staff recognition of restrictive practices and in recording instances following clear data collection principles.[119]

115 Legal Aid Qld, *Submission 141*.
116 Offices of the Public Advocate (SA and Vic), *Submission 95*.
117 For example, 10 Principles are identified in the National Safety Priorities in Mental Health: a National Plan to Reduce Harm: Mental Health Coordinating Council, *Submission 94*.
118 For example, Nonviolent Crisis Intervention Training: L Woolston, *Submission 89*.
119 National Mental Health Consumer & Carer Forum, *Submission 100*.