The Public Advocate
Influencing change to transform lives

5 September 2022

The Hon Anika Wells MP
Minister for Aged Care and Minister for Sport
PO Box 6022
House of Representatives
Parliament House
Canberra ACT 2600

Via email: Anika.Wells.MP@aph.gov.au

cc: The Hon Mark Butler MP, Minister for Health and Aged Care, Deputy Leader of the House: Mark.Butler.MP@aph.gov.au
cc: The Hon Yvette D'Ath MP, Minister for Health and Ambulance Services (Qld): health@ministerial.qld.gov.au
cc: agedcareprotections@heatlh.gov.au
cc: Mr Josh Burns MP, Chair of the Parliamentary Joint Committee on Human Rights: Josh.Burns.MP@aph.gov.au

Dear Minister,

I write to provide my views on the revised *Quality of Care Amendment (Restrictive Practices) Principles 2022*. I am writing to you, in addition to the nominated feedback agency, in order to highlight the significant concerns I hold about the proposed changes.

As the Queensland Public Advocate I have a statutory role to promote and protect the rights of adults with impaired decision-making ability.

The proposed *Quality of Care Amendment (Restrictive Practices) Principles 2022* seek to address several failings in the way the existing *Quality of Care Principles* regulate the use of restrictive practices in aged care settings. The August 2022 proposed amendments, however, are deeply flawed and amount, overall, to a chaotic and unsuccessful attempt to regulate this admittedly complex area. In particular, the interaction between the proposed scheme and existing state and territory substitute decision-making regimes will be both difficult to understand, much less operationally explain, and follows no obvious overall rationale. For these reasons the scheme will likely do little to improve the rights protection of people who are subject to restrictive practices in aged care settings.

I make three preliminary comments before looking at the detail of the proposed *Quality of Care Amendment (Restrictive Practices) Principles 2022*.

1. The first point is to note the **complexity** of the proposed scheme, in particular the interaction between it and existing state and territory substitute decision-making laws and practices. In addition to the confusing array of potential substitute decision-makers who might exist (with a new one of 'nominee' created by the scheme) the possibility will exist for the restrictive practices substitute decision-maker to be a different person to, for instance, an attorney appointed by the individual under an enduring power of attorney. While the person could still appoint that attorney as a nominee, the person may not be in a position to be able to do so if they no longer have the capacity to make that appointment (they may have appointed the attorney some time earlier). A person is at risk, through operation of the scheme, of having multiple substitute decision-makers in place. This could happen very easily in the following scenario. A person appoints their adult child to make medical decisions for them under an enduring power of

attorney. The person subsequently does not have capacity to appoint a nominee under the proposed scheme, and their partner accepts the role of restrictive practices substitute decision-maker. The partner is then the restrictive practices substitute decision-maker who can consent to chemical (and other) restraints, while the adult child is the medical decision maker. This would be very strange. There are other situations in which we could see multiple people potentially playing substitute decision-making roles for an individual by virtue of this scheme.

2. My second point is to reiterate an earlier view that I have put forward; namely that the only way to avoid this confusion is to recognise that **states and territories, and not the Commonwealth, are best placed to regulate restrictive practices**. My earlier suggestion along these lines has been to amend the Principles by simply requiring 'authorisation for the use of the restrictive practice to be given in compliance with any applicable law of the state or territory in which the care recipient is provided with aged care'.

3. My third point is to reiterate the view that I and an increasing number of other people have that **the consent paradigm is the wrong one for the authorisation of restrictive practices**. The scheme seeks to continue the 'consent/substitute consent' model for the authorisation of restrictive practices in the aged care sector at the very time the regulation of restrictive practices in the disability sector in Queensland is being reviewed, with the strong possibility that a 'Senior Practitioner' model may replace the current consent/substitute consent model that is in place in disability settings here. (I do note that the Commonwealth *Aged Care Act* obliges the Principles themselves to require 'informed consent' to be given to restrictive practices usage, and a recent amendment to this legislation specifies that the *Quality of Care Principles* 'may make provision for … the persons or bodies who may give informed consent to the use of a restrictive practice': but that itself warrants change, which would be relatively simple to achieve).

   As I have previously articulated in the restrictive practices reform options paper that I released on 5 October 2021 ('*Improving the regulation of restrictive practices in Queensland: A way forward*', available at https://www.justice.qld.gov.au/__data/assets/pdf_file/0011/697133/20211005-OPA-Restrictive-Practices-Reform-Options-paper.pdf), and in an opinion piece in Australian Ageing Agenda on 17 May 2022 ('*Stopping the inappropriate use of restrictive practices*'; https://www.australianageingagenda.com.au/clinical/stopping-the-inappropriate-use-of-restrictive-practices/), the consent/substitute consent model is sub-optimal when it comes to the authorisation of restrictive practices. In short the flaws of this model are that:

   - Requiring the consent of the person who is to be subject to a restrictive practice is somewhat odd, when one thinks about it, and typically unlikely to be meaningful;
   - It puts substitute decision-makers, who rarely (especially when they are private individuals) have clinical expertise with which to challenge any proposed restrictive practice usage, in the invidious position of having to make decisions that will often be about protecting others from the behaviour of the person for whom they are making decisions;
   - It is also an unusual step to take, in a human rights sense, when we are seeking to move away from creating more instances of substitute decision-making (as per Article 12 of the United Nations *Convention on the Rights of Persons with Disabilities*).

4. I turn here to address some particular observations about the 2022 proposals, which I will deal with in the order of the proposed hierarchy of decision-makers.

5. **Restrictive practices authority**.

The possibility of an attorney playing this role has been removed, which means a person cannot make their own appointment to this role. It remains unclear whether a guardian for personal matters in Queensland would satisfy the criteria for appointment here as a 'restrictive practices authority', as the definition of that term requires that to be 'an individual or body that, under the law of the State or Territory in which the care recipient is provided with aged care, has been appointed in writing (other than by the care recipient) as an individual or body that can give informed consent to the use of the restrictive practice in relation to the care recipient if the care recipient lacks capacity to give that consent'. In Queensland, Chapter 5B of the *Guardianship and Administration Act 2000* enables the appointment of guardians for restrictive practices in relation to disability services; this does not extend to aged care services, and it is not clear yet in Queensland whether a guardian with power to make decisions concerning 'personal matters' has power to authorise restrictive practices (my office's view on the current law is that they probably do have this power). I note also the wording around the definition of 'restrictive practices authority' includes the words 'appointed in writing'. This seems odd, though I understand this would be to avoid any automatic appointment.

6. **Nominee**.

The concern I have here is that the only possibility for a personal appointment is of a nominee. A person may previously have appointed an attorney under an enduring power of attorney to make decisions on their behalf. While they could appoint the same person to the role of nominee, they may not have the decision-making capacity to do so when the need for restrictive practices authorisation is enlivened. So a person who has been appointed by the person to make decisions for them may not be the person who ends up making substitute consent decisions for them in authorising restrictive practices to be applied to them. There is also the possibility that a person could appoint someone as nominee who is different to their medical decision maker, for instance. In either case there could be two different people playing substitute decision-making roles for the individual. This would be odd and confusing for everyone involved.

An additional concern about the new 'nominee' provisions is that there are no apparent safeguards around the appointment of a nominee, such as any witnessing requirements. While the nominee appointment can only be made where the 'care recipient has capacity to do so', there is no requirement for anyone to independently attest that the person understands what they are doing when they purport to appoint a nominee (as exists for the appointment, for instance, of attorneys under enduring powers of attorney). In addition, while the proposed amendments specify that 'a member of the service staff' can only be a nominee where they are a relative or partner of the individual concerned, there should be other requirements disentitling others with a potential conflict of interests from playing the role of nominee.

7. **Partner, Relative or Friend**.

I deal with the next three possibilities together. The concern here is that these people will have significant power to authorise a restrictive practice. While they would have to agree to the role, the person subject to the restrictive practice may not want them in this role, and the person at the centre of this may not have the decision-making capacity to appoint someone else (as a nominee) to the role. While we enable medical treatment decision-makers to be appointed under an automatic statutory hierarchy, this is largely unproblematic. Authorisation of restrictive practices is not unproblematic. Ordinarily we require someone with such power, who has not been appointed by the person to the role, to be appointed by a tribunal, with the safeguards and oversight that involves.

8. **Medical treatment authority**.

The possibility of an attorney (under an enduring power of attorney) playing this role has been removed, which means a person cannot appoint someone as their 'medical treatment

authority'. The proposal is that a guardian would play this role. There are several problems with this.

a. First, a person will likely have a health decision maker (e.g. a statutory health attorney, or someone appointed under an enduring power of attorney in this role). However this person would not fulfil the requirements to render them a medical treatment authority (which is defined so that the appointment must be in writing but not appointed by the person). So a person (if they needed to get to this level on the hierarchy) could have different people playing the role of medical decision maker and medical treatment authority, which would be very odd.

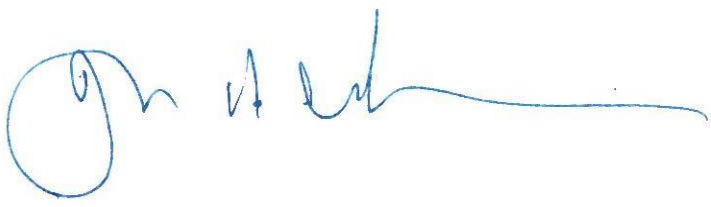
b. Second, as I have previously argued, this proposal would give such a person far more power than they have under existing state and territory law. The idea here is that the person who can play this role is 'an individual or body that, under the law of the State or Territory in which the care recipient is provided with aged care, has been appointed in writing (other than by the care recipient) as an individual or body that can give informed consent to the provision of medical treatment (however described) to the care recipient if the care recipient lacks capacity to give that consent'. This would be a guardian. Ordinarily a guardian with power to make medical decisions would typically have power to make decisions in relation to 'health care', which is defined in Queensland (*Guardianship and Administration Act* schedule 2) as 'care or treatment of, or a service or a procedure for, the adult — (a) to diagnose, maintain, or treat the adult's physical or mental condition; and (b) carried out by, or under the direction or supervision of, a health provider'. This does not extend to authorisation of restrictive practices, even restrictive practices in the form of chemical restraints. As I have previously argued, this development would lead to all sorts of new requirements in educating people about the role of guardians in the future, whose power to make health care decisions could, by virtue of the proposed *Quality of Care Principles*, extend to the power to authorise someone being locked in their room. This development would also mean that existing guardians with power to make health care decisions would have the power to authorise restrictive practices, even though the appointing tribunal (QCAT in Queensland) will have made the appointment without anticipating that the guardian would have this power.

9. A final point to note is that the removal of personal appointments from the role of 'medical treatment authority' will mean, as indicated above, that guardians will be appointed to the role. This will ordinarily involve appointment of the Public Guardian, as a person who might be appointed as a private guardian would likely be appointed earlier in the scheme. This will have significant cost implications for QCAT and particularly for the Public Guardian.

Thank you for the opportunity to comment on the revised *Quality of Care Amendment (Restrictive Practices) Principles 2022*. As you can see, I consider them to be a deeply flawed attempt to wrestle with an admittedly complex regulatory problem.

Please don't hesitate to contact me if you would like further elucidation of the points I raise here.

Yours sincerely,



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