The Public Advocate
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Improving the regulation of restrictive practices in Queensland: a way forward

1. Introduction

Restrictive practices are a method of restricting a person's freedom, usually against their will; they can include the use of physical, mechanical, environmental, or chemical restraints, or seclusion.

Restrictive practices include;

- isolating someone from other people by not allowing them to move in or out of certain areas (seclusion);
- using medications to control certain types of behaviour (chemical restraint);
- holding someone so that they cannot move away (physical restraint);
- using objects like suits or straps or other equipment to stop someone moving freely (mechanical restraint);
- locking doors or cupboards so that someone is prevented from moving about freely or participating in an activity (environmental restraint).

Restrictive practices are used when the behaviour of someone is considered unsafe, and there is a risk that the person may hurt themselves or other people.

For people with impaired decision-making ability, restrictive practices are most often used in settings such as disability services, residential aged care facilities and health care services like hospitals.

The use of any restrictive practice affects the human rights of the person involved. Without proper authorisation, the use of a restrictive practice may be an offence against the person on whom it is used. Under criminal law, restrictive practices may constitute an assault, or an unlawful deprivation of liberty.

Due to the potential legal and human rights impacts associated with the use of restrictive practices, it is vitally important that their use be minimised, and ideally eliminated, and that such practices be regulated in a clear, transparent, and appropriate way.

Regulations that authorise and monitor the use of restrictive practices should encourage minimal usage of restrictive practices, provide conditions for their use, include safeguards and protections for those people on whom they are used, and contain clear guidance for those who use them (including disability support workers, nurses, and aged care workers).

2. Current problems

There are two problems concerning restrictive practices authorisation. The first relates to the legal uncertainty surrounding the use of restrictive practices. The second concerns the current authorisation model.

a. Uncertainty

The legal frameworks relevant to the authorisation of restrictive practices across Australia are complex. The laws regulating restrictive practices differ between each state and territory, and there are also inconsistencies in how practices are reported and classified.

In Queensland, the *Guardianship and Administration Act 2000* and the *Disability Services Act 2006* provide a specific framework for the authorisation of restrictive practices usage in disability services

settings. The *Mental Health Act 2016*, meanwhile, regulates the use of restrictive practices in mental health facilities.

There are currently no specific authorisation frameworks for the use of restrictive practices in residential aged care or general health care settings.

Recent changes to the Commonwealth *Quality of Care Principles* (which are made under the *Aged Care Act 1997*) have introduced a consent-based model for the use of restrictive practices in residential aged care facilities. This requires a 'restrictive practices substitute decision-maker' to consent to the practice if the person themselves is unable to do so. A 'restrictive practices substitute decision-maker' is defined as 'a person or body that, under the law of the State or Territory in which the care recipient is provided with aged care, can give informed consent' to the particular restrictive practice.

In many states and territories, including Queensland, it is unclear exactly who would have the authority to consent to a restrictive practice in a residential aged care setting. An attorney for personal matters under an enduring power of attorney, and a guardian appointed by the Queensland Civil and Administrative Tribunal (QCAT), may have such power in Queensland, however this is far from certain.

This uncertainty has left aged care providers unsure of their obligations under the changed *Quality of Care Principles*.

Even within disability services in Queensland, for which there does exist a restrictive practices authorisation framework, there is complexity and some degree of uncertainty.

The Queensland disability services authorisation framework is a consent-based model, with decision-makers (depending on the particular restrictive practice and the length of time for which it will be authorised) including QCAT, the Public Guardian, private guardians appointed to approve restrictive practices, and the Chief Executive of the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships.

While the framework itself is complex, the roll-out of the National Disability Insurance Scheme has added further national requirements in relation to the use of restrictive practices on NDIS participants. These requirements, which form part of the NDIS Quality and Safeguards Framework and which enable the usage of restrictive practices, and the quality of behaviour support plans, to be reviewed and monitored, include the requirements: to use registered behaviour support practitioners when developing behaviour support plans that include regulated restrictive practices; to lodge behaviour support plans with the NDIS Quality and Safeguards Commission; and to provide monthly reports on regulated restrictive practices usage to the Commission.

The roll-out of the NDIS in Queensland has also resulted in a proliferation of new disability service providers; they are all required to comply with the complex regulatory system when using restrictive practices.

b. Consent-based models are sub-optimal

The second problem when it comes to restrictive practices authorisation is that the consent-based model – which applies to restrictive practices usage in disability services in Queensland, and which is envisaged to apply in aged care settings under the *Quality of Care Principles* – is a sub-optimal way of meaningfully regulating restrictive practices usage.

Consent-based models require either the person themselves, or someone on their behalf, to 'consent' to a restrictive practice. In addition to the above-mentioned uncertainty about which substitute decision-makers actually have lawful authority to consent to restrictive practices outside disability settings, there are three problems with consent-based models.

First, the idea that the person themselves could or should meaningfully consent to a restrictive practice is an odd one, at least in the context of some restrictive practices. Applied to a potential restriction on a person's free movement this would be tantamount to a person saying: 'I consent to you preventing me from leaving the building even when I say I wish to leave the building'.

Likewise, the requirement for substitute consent, when the person themselves does not have the capacity to consent to the practice, is problematic. Modern human rights developments are increasingly requiring any substitute decision-makers to make decisions that the person themselves would likely have made. This means, in the context of restrictive practices authorisation, substitute decision-makers should only consent to restrictive practices that the person themselves would likely have consented to. Again, this conjures up odd scenarios.

Second, and perhaps more significantly, the idea that a substitute decision-maker should be responsible for authorising a restrictive practice puts them in an unusual and sometimes invidious position. Substitute decision-makers are ordinarily put in place to ensure a person's wellbeing. People appoint attorneys (often relatives) under enduring powers of attorney to make financial and/or personal decisions that accord with their will and preferences. Guardians and administrators are appointed by guardianship tribunals (QCAT in Queensland) for similar reasons.

While restrictive practices can be utilised to protect the person themselves from coming to harm, they are also used to protect other people from the behaviour of the person. Requiring substitute decision-makers to authorise restrictive practices puts them in the position of seeking what's best for the person, as well as making decisions to ensure the safety of others around the person. This type of decision-making places a considerable burden on substitute decision-makers, who will inevitably feel pressured to consent to the practice (or risk the person, often a loved one, harming someone else).

The third limitation concerns expertise. It would be rare for a person on whom a restrictive practice is proposed, or for their substitute decision-maker (especially in the case of private guardians and attorneys), to have the clinical expertise to identify other less restrictive means of dealing with the circumstances that have given rise to the request to use a restrictive practice. A person who has been appointed under their parent's enduring power of attorney, and suddenly finds themselves being asked to consent to a chemical restraint, cannot be expected to know, for instance, other behavioural approaches, or environmental changes, that may make the restrictive practice unnecessary. This means the 'consent' safeguard – certainly when it involves people who have not had experience in the role before – will rarely operate effectively.

3. A way forward

Queensland needs a legal framework for the authorisation of restrictive practices that reduces the use of restrictive practices, is easy to understand and use, provides adequate protections and safeguards, and can be applied consistently across settings.

Key principles, objectives and requirements underpinning any framework should include:

- The goal behind the restrictive practices framework is the reduction, and ideally elimination, of the use of restrictive practices.
- The human rights of the person concerned are the paramount consideration when a restrictive practice is proposed.
- Any restrictive practice is the least restrictive intervention possible and is only used:
  - as a last resort, after alternative strategies have been considered;
  - for the shortest amount of time possible;
  - to prevent serious physical harm to the person or another person;
  - to the extent necessary and proportionate to the risk of harm;
  - with the approval of a person authorised by law to make this decision;

  - as prescribed in the person's positive behaviour support plan;[1] and
  - when subject to regular review.
- Authorisation processes and appeal mechanisms are transparent and easy to understand.
- All authorisations to use restrictive practices are documented.
- Behaviour support plans are person-focussed (not behaviour-focussed) and subject to rigorous quality control mechanisms and review.

The proposed solution to the challenge of regulating restrictive practices is the adoption of a **'senior practitioner'** model, which operates using authorisation rather than consent, and which could be applied across various settings.

This model would involve the appointment of a Queensland Senior Practitioner, who would approve the appointment of appropriately trained Authorised Program Officers. Authorised Program Officers would be responsible for authorising restrictive practices according to individually-tailored positive behaviour support plans, lodged by service providers and reviewed by the Senior Practitioner. The model could also require the specific approval by the Senior Practitioner of particular restrictive practices.

The Senior Practitioner would ideally exist as part of a government agency or commission and possess the necessary expertise to appropriately assess positive behaviour support plans and oversee the use of restrictive practices. Transparency and accountability also constitute key components of the framework, which would involve Senior Practitioner reporting requirements, as well as appropriate internal and external mechanisms through which authorisation decisions could be appealed.

This model could, and ideally should, operate consistently across multiple settings, including disability services, residential aged care facilities and health care. It also has the potential to be applied in other contexts, including in educational and residential settings for children, including out-of-home residential care.

It is anticipated that the framework would streamline the authorisation process for service providers, as well as reducing the complexity of the current state system that exists for disability services (which sees significant pressures placed on key agencies within the guardianship and administration system, including the Public Guardian and QCAT).

In addition to the authorisation of restrictive practices, the Senior Practitioner could also be responsible for the provision of information and education regarding the use of restrictive practices in Queensland.

By establishing a single source of information and assistance, and a single authorisation process, we are much more likely to see service providers in a variety of fields complying with well-established and understood authorisation processes for the use of restrictive practices. We are also more likely to see the reduction of restrictive practices usage, and significant steps taken toward their elimination.

Office of the Public Advocate (Qld), Reform Options Paper, 5 October 2021.

[1] Positive behaviour support plans are designed to identify the positive interests and behaviour of a person, and to identify causes when a person's behaviour poses risks to themselves or to others. These plans point to strategies to avoid and de-escalate behaviour that causes risks to the person or to others, and clarify situations when restrictive practices can be used, with a focus on the reduction and elimination of their usage.